

DOCTORAL THESIS

“Lifting the Burden” Art Therapy for Survivors of Intimate Partner Violence

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**“Lifting the Burden”
Art Therapy for Survivors of Intimate Partner Violence**

by

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ABSTRACT

Intimate partner violence is a prevalent problem throughout the world and is associated with significant physical as well as psychological impairment for women. Few studies are available to fully illuminate which interventions are most beneficial in healing and empowering women after their experience of violence in an intimate relationship. Although many traditional as well as creative approaches (Cognitive Behaviour Therapy, Person-Centred Therapy or Creative Arts Therapies) are used in practice, much of the work with survivors is not grounded in empirical research. In the present study the effects of Art Therapy in comparison with Person-Centred Therapy and routine intervention without additional therapy have been measured by quantitative as well as qualitative means. Measures of self-efficacy, self-esteem, depression, symptoms of PTSD and general psychological well-being were administered to a sample of survivors of intimate partner violence at baseline, end-of-treatment and follow-up. Therapy experience has been the focus of one-on-one interviews with participants. In general, all intervention groups improved on most outcome measures at follow-up. Participation in either of both therapeutic interventions in addition to routine care, however, contributed to improvements in difficulties related to phobic anxiety and impaired self-reference. Art Therapy was particularly effective in improving general psychological wellbeing and in particular self-efficacy, self-esteem, depression, somatic problems and several debilitating symptoms of PTSD.

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No man is an island!

And because no woman is an island either, the official acknowledgement and appreciation of all the individuals who have helped turn this research idea into a project – and into a thesis, is very important to me. A great number of people have influenced me as much as the project since the birth of its idea seven years ago. Unfortunately, there will not be enough space to mention everyone besides a very few, so this big Thank You goes out to all those who I am not able to name but have nonetheless shaped this study or sent me some words of encouragement. Thank you to those individuals for their inspiring conversations, compliments and constructive critiques, input or food for thought.

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INTRODUCTION

In the 20th century, violence has become more and more visible. Media routinely brings terrorism, war and murder into living rooms and into public awareness. Unfortunately, one form of violence still only makes the news in dramatic cases or when a celebrity is involved (Grana, 2001). Domestic violence, violence perpetrated and managed privately behind closed doors, still remains almost invisible. This so called “hidden violence” often goes unnoticed or is even tolerated by society to an alarming extent despite the fact that in most cases, an outsider, such as a health care professional, friend or neighbour, is aware of it (Stanko, 2006).

Domestic Violence, the physical and psychological aggression between family members, is recognised as a social and health problem world wide (Hawkins & Humes, 2002; Koss & Hoffman, 2000). In the literature, domestic violence is defined as the use of fear, intimidation, and violence by one member of the family to verbally and/or physically harm and to control the actions, feelings and beliefs of another (Paul, 2004). Violence between intimate partners in a relationship, often termed more specifically Intimate Partner Violence (or IPV), includes any behaviour within an intimate relationship that causes physical or psychological harm. This includes physical aggression, psychological violence (such as intimidation, humiliation), forced intercourse and social coercion, as well as controlling behaviours such as isolation, and control over every day movements (Hegarty, Taft & Feder, 2008). Both men and women can be victims of violence and abuse from an intimate partner with grave consequences. Violence perpetrated by men against their female partners however, remains one of the greatest causes of injury to women (Dwyer, Smokowski, Bricout, & Wodarski, 1995) and it has

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been made clear that abuse can happen in marriages or cohabiting and dating relationships of individuals regardless of social class and cultural or religious background (Carden, 1994; Ganley, 1995; Koss & Hoffman, 2000; Pagelow, 1992).

Violence and abuse of any kind are horrific experiences for those who are confronted by it, frequently leaving survivors distressed and traumatised (Cambell, 2002; Golding, 1999; Krug et al., 2002). Physical aggression and psychological violence in the home causes not only immediate suffering and injury to an individual but may, directly and indirectly, impair physical and psychological functioning for long periods of time (Cambell, 2002; Golding, 1999; Krug et al., 2002; Logan & Walker, 2004; Peterson & Seligman, 1983). It is believed that up to 1 in 10 female users of health care facilities is a survivor of IPV (Humphreys et al., 2001). Similarly, it has been suggested that 50 to 90% of women with a history of interpersonal violence are users of the mental health services (Stenius & Veysey, 2005). Besides physical injuries, other serious conditions such as Post Traumatic Stress Disorder (PTSD), depression, anxiety, cognitive challenges (including pessimistic thinking, poor judgement, and ineffective coping mechanisms), somatic complaints, as well as decreased self-esteem and self-efficacy are often immense problems women in abusive relationships face (Kubany et al., 1995; McCloskey & Fraser, 1997; Roberts, 1998; Paul, 2004; Walker, 1984). It is therefore clear that abuse between intimate partners is a problem that cannot be ignored and should not be minimised.

Compared to stranger violence, domestic abuse poses additional difficulties. When abuse is perpetrated in the home, a place generally valued as safe and comfortable, the perpetrator is a friend, family member or intimate

partner (Tolan, Gorman-Smith, & Henry, 2006). Violence between family members, and particularly between partners in an intimate relationship, is not random but thought to be the result of one person's desire to gain or maintain power and control over the other (WAFE, 2006; E. Walker, 1986). The perpetrator of family violence has ongoing access to the victim who might be dependent on him physically, financially or because of their children (Ganley, 1995). IPV therefore poses a complex problem for individuals who experience it, as well as for those in the helping professions. Ending violence against women has been an important aspect of feminist work and has fuelled countless international debates and social action (Agnew-Davis, 2006). Advanced campaigns against domestic violence and the resulting increase in public awareness have made it easier for survivors to disclose their experiences and take action against their abusers, without fear of being misunderstood or disbelieved. With the expansion of the Domestic Violence, Crime and Victims Act in 2004, perpetrators of IPV are being prosecuted more rigorously and more determined actions are being taken to tackle the problem in the UK. The necessity and benefits of treatment of both perpetrators and survivors is without a doubt a crucial part of the work of social and health professionals dealing with domestic violence. The diagnosing of survivors in mental health services however, has raised concerns about pathologising and categorising women and therefore missing opportunities for empowerment. Labelling a survivor as having mental health needs is also thought to take the responsibility for the negative effect of abuse away from the abuser (Humphreys & Thiara, 2003). Despite the existing debate about diagnosing and labelling and its contribution to the 'medicalisation' of gendered violence while taking the attention even more away from the political

injustice of violence against women (Humphreys & Thiara, 2003), it is clear that appropriate and prompt intervention to those affected by violence is crucial for an improvement in quality of life and health. On the other hand they can represent an effective starting point for intervention and healing, rather than a label contributing to stereotypes or stigma.

The idea of therapy for survivors of IPV itself has also been under debate during the past decades (Agnew-Davis, 2006) and there are strong opinions about the usefulness and necessity of available therapeutic services. Therapists agree that therapeutic intervention (especially early intervention) can significantly reduce the impact of abuse on the lives of women (Paul, 2004) while activists and professionals in the field believe that treating the individual woman labels already marginalised women and takes attention away from the true social issues. Despite the debate, it has been felt by professionals and researchers alike that health care professionals have a unique and crucial opportunity to assist survivors of IPV (McCaw et al., 2007). However, there is still uncertainty among professionals, particularly those in health care agencies, about which interventions are the most appropriate for survivors of IPV (Ramsay et al., 2005).

Little research is available on current approaches to intervene with women who have experienced abuse. In addition, survivors are frequently in complex situations, which not only make the choice of treatment a difficult one but also warrants the use of interagency, unique or different approaches which do more than alleviate women's symptoms. One important resource is thereby the availability of refuges or community-based domestic violence agencies. In many cases, refuge staff offer a great amount of services to their residents including crisis intervention, house meetings and one-on-one conversations. However,

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additional therapy is rarely available. When therapy is offered, therapists commonly use psycho-educational approaches, anxiety management techniques, psychopharmacology, or feminist therapy perspectives in the work with women (McCloskey & Fraser, 1997). In recent years, psychotherapy has moved away from the “talking cure” as the therapeutic approach to the use of new and eclectic approaches in a variety of settings (Tallis, 1998). Through the introduction and implementation of novel ideas in counselling individuals seeking the service of a mental health professional may now be able to find help through approaches like Art, Music, or Dramatherapy (Carlson, 1997; Hanes, 2000; Kramer, 2002). Art Therapy in particular has been proposed to be a valuable tool for women and children in refuges. Although often seen as non-traditional, innovative creative arts approaches have much to offer in the area of domestic violence. For most individuals language and words are the main means of communication the verbal exchange in therapy therefore the most useful tool. The philosophy of Art Therapy however, builds on the premise that human experience cannot be entirely reduced to words and that some emotional states are beyond words (Edwards, 2004). It has often been asserted that art making is inherently therapeutic and by using this mode of communication, Art Therapy offers something that cannot be provided by many other disciplines (Kaplan, 2000). It enables individuals to effect personal change and growth using art materials (Odell-Miller, Hughes, & Westacott, 2006) and images are used to understand and communicate events, associations and feelings. For that reason, Art Therapy has been influential in the work with sufferers of various types of trauma (Brooke, 1995; Cooper & Milton, 2003; Laub & Podell, 1995). Many survivors of IPV have experienced terrible and humiliating times and situations, in therapy it might not be easy to describe their

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experiences in words. The successful use of this approach with other, similar populations shows immense potential for its application in the work with survivors of domestic violence. In many institutions, including refuges or domestic violence shelters, Art Therapy is becoming an important part of treatment and agencies working with survivors are using this approach increasingly (Lagorio, 1989; Palmquist, 2003, Walters, 2005).

Both the field of Art Therapy and the area of domestic violence have been the subject of research in the past. To the author's knowledge a union of these two areas, the application of Art Therapy with survivors of domestic violence, has not been empirically evaluated by other professionals. Few outcome studies exist that focus on the efficacy and effectiveness of therapy in refuges and none specifically on the use of creative therapies, in particular Art Therapy, with this particular population. The lack of empirical research in these areas has been criticized by several authors in the recent decades (McNiff, 1998; Burtleigh & Beutler, 1997; Payne, 1993). Art therapy research often consists of case studies and results of qualitative approaches such as interviews and client observation. Although these approaches are extremely helpful and often ground breaking, Art Therapists still find themselves in the position of having to substantiate the success of their approach. In addition, it has been noted that outcome studies often have little relevance for clinical practice because of their focus on scientific methods and the presentation of empirical findings frequently only available to other researchers (Goldfried & Wolfe, 1998; Seligman, 1995). Research in practice however is difficult to implement. Many practitioners are reluctant to engage in research because of time constraints, limited funding, or the difficulties of combining and using empirical inquiry with the introspective skill of both art and therapy

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(McNiff, 1998; Payne, 1993). Because the benefits of Art Therapy for the mental health profession have only recently enjoyed increased support, the need for current research and evaluation is a prominent one. It is the author's hope to make a contribution to the collaboration between researchers and clinicians by producing research outcomes useful to the practicing therapist.

For the reasons discussed above, the need for effective interventions for women survivors as well as the need for the empirical evaluation of Art Therapy, this unique approach has been deemed as worthy of investigation. The idea behind the current thesis is the importance of appropriate intervention for survivors. As mentioned above, inspiration to conduct this research has been drawn from several interrelated fields: the area of domestic violence, Art Therapy and intervention research. As pointed out by Paul (1967) in a well-known quote "studies must examine not just the effectiveness of given treatments, but what treatment, by whom, is most effective for this individual with that specific problem under which set of circumstances" (Paul, 1967, p.111). The concern of the current thesis is in particular on the examination of what treatment is most effective for survivors of IPV after the experience of abuse. A neutral stance has thereby been purposely adopted. Often, work with women who have experienced violence is coloured and shaped by theoretical orientations such as feminism or social constructionism. In the following thesis, such an orientation has not been placed in the foreground, rather a viewpoint acknowledging all the influences on area of domestic violence and their unique and crucial contributions to research and practice has been attempted. This decision has been influenced by a wish to evaluate therapeutic interventions that not only span across theoretical models but can also be used in or expanded to fit a variety of settings. In this sense, an

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attempt has been made to go beyond the limits of one theoretical orientation. It has been the author's intention to make a contribution to the collaboration between researchers and clinicians by producing research outcomes useful to the practicing therapist. It is hoped that the results of the study will not only enhance the repertoire of appropriate and beneficial therapies, thereby adding empirical knowledge to the field of Art Therapy, but also provide health professionals in practice with useful tools in the work with survivors of IPV.

In this exploratory study, an experiment examining the effects of Art Therapy, in comparison with therapy from a Person-Centred perspective, on women recovering from IPV was conducted using standardised measures in addition to face to face interviews. The following pages will give insight over the ideas, the work and the methodological factors influencing this study and its design. A foundation to the field of domestic violence as well as the current standards of practice in therapy with survivors will be laid out in the literature review and the work undertaken with participants in British refuges will be described in detail. Most importantly, findings and their implications for practice will be discussed in detail and comprise the most crucial component of this thesis.

CHAPTER 1 REVIEW OF THE LITERATURE

1.1. The Problem of Domestic Violence

1.1.1. Definition of Domestic Violence and Intimate Partner Violence

Domestic violence and its patterns have been defined in a variety of ways throughout the past decades. However, defining abuse between family members is difficult and its boundaries are not clear cut (Gill, 2004). The early focus on physical abuse between intimate partners has been widened to include psychological abuse as well as sexual violence, two forms of domestic abuse that had not been considered as such for several decades (Follingstad & DeHart, 2000). It is now recognised that all forms of abuse, including physical, sexual and emotional aggression, have an immensely negative impact on survivors and often occur simultaneously in an abusive relationship (Pagelow, 1992). Much research of the 21st century includes stalking and cultural specific forms of domestic violence such as forced marriage, genital mutilation, and so-called ‘honour crimes’ (Fischbach & Valentine, 2007). Although there is no shortage of definitions for domestic violence, appropriate legal and behavioural characterizations of the basic features, along with its terminology, are still under debate (Kilpatrick, 2004). The term family violence is commonly used for acts which encompass any violence and abuse in a family-type relationship, from aggression between partners in an intimate relationship to abuse between siblings or from children towards their parents. This can also mean physical, sexual and psychological violence aimed at older family members and children or violence perpetrated by women against their male partners (Yamamoto & Wallace, 2007). A more careful definition of Intimate Partner Violence (IPV) is used by domestic violence organisations such as the Women’s Aid Federation of England. This

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definition includes “any physical, sexual, psychological or financial violence that takes place within an intimate or family-type relationship and that forms a pattern of coercive and controlling behaviour” (WAFE, 2006). This violence within the intimate relationship can include threat, force, as well as the different types (Walby & Allen, 2004). In many cases, violence between intimate partners is defined in very simple terms as “any violence between current or former partners in an intimate relationship, wherever and whenever the violence occurs. Violence may include physical, sexual, emotional, or financial abuse” (Walby & Allen, 2004, p.4). This broad definition includes heterosexual couples in marriages, dating and cohabiting couples as well as individuals in homosexual relationships. In recent publications it has been proposed that, for a better understanding of domestic violence, a distinction should be made between the motives of the perpetrator to use violence and different types of abusive relationships which might result (Johnson & Ferraro, 2000; Neale, 2002). This distinction will be discussed in more detail in section 1.1.5. While recognising that domestic violence happens in all types of relationships with negative effects on the survivor, regardless of gender or age, women comprise the overwhelming majority of domestic violence survivors, suffer more serious injuries in violent incidents and frequently experience abuse from the same partner more than once (Browne, 1993; Pagelow, 1992; Walby & Allen, 2004). The terms chosen in order to define violence and abuse can have an immense impact on how domestic violence is portrayed as well as perceived. Appropriate terminology has been discussed numerous times (Muehlenhard & Kimes, 1999; Tolan, Gorman-Smith & Henry, 2006). Researchers and clinicians have moved away from terms such as ‘wife battering’ or ‘spouse abuse’ as they not accurately describe the complex

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nature of violence between partners. In the current thesis, intimate partner violence (IPV) will be used as it more accurately describes the topic under discussion. This term has been chosen to describe not only a broader range of abusive relationships but is also meant to include various types of abusive behaviours. IPV also describes a pattern of behaviour rather than single acts. Based on the recent findings, the following thesis will focus primarily on the violence perpetrated against women in intimate relationships. The term *Domestic Violence* will be used interchangeably with IPV to refer to violence between partners within the confines of a relationship as well as the other forms of violence within the home where it is applicable.

IPV may take the form of physical violence, sexual aggression or rape, and emotional/psychological abuse which includes coercion, isolation, limited and controlled access to family resources, and destruction of property (Gosselin, 2007). Physical abuse is defined as the use of force with the intent to inflict injury (Koss & Hoffman, 2000). Commonly, such physical contact entails pushing, choking or strangling, hitting with fists, kicking, throwing objects, using weapons or pulling hair (Walby & Allen, 2004). Anderson and colleagues (2003) found that being shoved, pushed, kicked and grabbed was the most common physical abuse reported by survivors along with destruction of household items. Sexual abuse, including marital rape, is defined as non-consensual and unwanted sexual contact such as intercourse or penetration through force or threat of force, indecent touching or forced prostitution (Gosselin, 2007). Sexual abuse can include acts, which are not violent but nonetheless coercive, such as refusing to wear condoms or discussing sexual matters (Campbell & Soeken, 1999). Coercion is a set of tactics (physical as well as psychological) used to elicit

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particular responses and incidents of such tactics are cumulative rather than specific to certain situations (Stark, 2007). Coercive control can be a pattern of different combinations of violence or abusive tactics applied to dominate a partner. Emotional or psychological abuse are patterns that can include the control of every day activities as well as major life decisions (Campbell, Sullivan & Davidson, 1995), damage of property or pets, threats of harm to the victim herself or loved ones, verbal attacks and humiliation with an emphasis on vulnerabilities, manipulation and 'mind games' (Gosselin, 2007). In an extensive study, Follingstad and colleagues (1990) identified several forms of psychological/emotional abuse experienced by women. They are summarised as verbal attacks (ridicule and humiliation), isolation (social and financial), jealousy and possessiveness, verbal threats of harm, threats of divorce or abandonment and destruction of personal property. Ridicule was the most commonly experienced form of emotional abuse by women in this study (Follingstad, Rutledge, Berg, Hause & Polek, 1990). Survivors in similar studies report that verbal abuse most often included yelling, name-calling, breaking promises, and lying (Anderson et al., 2003). Eighty two percent of women were blamed for their abusers' problems and women are frequently told that they are crazy and not wanted by others (Anderson et al., 2003). Culture and immigration status might inform specific control tactics including destroying or keeping immigration documents from women or controlling access to language services (Ganley, 1995; Sorenson, 1996). Some tactics, such as regulation of food or sleep, confinement, isolation, or the enforcement of strict cleaning and caretaking rules can be similar to methods used with prisoners (Ganley, 1995) or hostages (Seeley & Plunkett, 2002). In combination with isolation from friends and family, alternative sources of support

or information, intimidation (insults, shaming, indirect and private signals of imminent harm) and constant surveillance these tactics greatly reduce a woman's sense of worth, increase fear and are employed to create a dependence on the abuser (Gosselin, 2007).

1.1.2. Prevalence of Intimate Partner Violence

Violence of men against their female partners has existed for thousands of years (Edelson, 2000; Muehlenhard & Kimes, 1999) and was not considered a problem but rather normal and part of the role of being a wife and mother (Walker, 1968). In the 21st century, domestic violence is internationally acknowledged as a problem which is not only a grave human rights violation (Hawkins & Humes, 2002) and a major health concern (Koss & Hoffman, 2000), but also presents an immense financial impact on a country due to health care bills, legal expenses, lack of productivity and absenteeism from work, housing costs and money spent through social services. In a report based on data from 2001, the cost of domestic violence in the UK alone is estimated to be £23 Billion annually (Walby, 2004).

Although reports of its prevalence differ considerably from country to country, no culture can present a lack of violence against women (Fischbach & Valentine, 2007). Research on lifetime prevalence of IPV throughout the past two decades has shown that it impacts between 10% and 69% of women in the world (Koss & Hoffman, 2000; Krug et al., 2002; Walby, 2004). Violent families make up between 2% and 16 % of the communities in the UK and the United States and approximately 525,000 new cases of domestic violence are reported annually in

the UK alone (RESPECT, 2004). It is believed that the current statistics of domestic violence are estimates (Straus, Gelles, & Steinmetz, 2003).

The diversity in the numbers makes a true estimate of the prevalence of domestic violence difficult. There have been considerable differences in the collection of information and reporting of domestic violence in the past (Wilt & Olson, 1996). Inconsistencies in data and the wide span between figures are in part due to differing definitions of violence and what constitutes it, under or over reporting in a certain population, the type of questionnaires and methodologies used, as well as the variety of individuals under investigation (Loseke, Gelles, & Cavanaugh, 2005). According to Gill (2004) the true estimate is difficult to establish due to the “private nature of domestic abuse, the lack of definitional consensus regarding types of violence, the methodological limitations in conducting such sensitive research [...] and the reluctance of women to report these crimes often keeps the scale and severity of the violence hidden” (Gill, 2004, p.4.).

Fundamental aspects such as the definition of domestic violence vary greatly between studies and further complicate attempts to compare previous research studies or to combine results to better understand its prevalence (Gelles, 1987). Some investigators of violence against women and children have included psychological and/or sexual abuse in their definition, while others have concentrated on physical abuse only. Recently, with a greater multicultural understanding, previously ignored forms of domestic violence, such as forced marriage and so-called ‘honour crimes’, have also been included in the domestic violence research and literature. Researchers have explored data in emergency rooms and hospitals or have accessed medical records in the gathering of

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information while others have relied on refuges, counselling centres, or social service facilities for the collection of data about IPV. Research is mainly based on women who actively seek help. However, this group may comprise just a small subset of survivors of IPV and is not representative of the entire population. Rarely are researchers able to include data from women who still live with their abusive partners, are homeless or incarcerated, or are individuals who are non-fluent English speakers (Browne, 1993).

The notion of under-reporting continues to remain an important one, particularly in studies evaluating violence within the general public. Despite the vast amount of research in the field it is still believed that domestic violence is much more prevalent than commonly believed (Gelles, 1987; Mihalic & Elliot, 1997) and that current numbers represent the only 'tip of the iceberg' (Wilt & Olson, 1996). Even women who do request treatment for marital problems disclose information about violence and aggression reluctantly and often present other health related complaints when seeking help, rather than IPV (Cascardi, O'Leary, Lawrence & Schlee, 1995). The belief that affairs between family members within the home are private and cannot be considered illegal has deep roots and is still prominent in many cultures. Few families are willing to reveal their marital problems and acts of violence to other family members or friends. Disclosing this kind of personal information to a third party such as a researcher, or even a therapist, might be met with disapproval and shame by other family members. Fear of being blamed for the abuse and the responsibility of keeping the family's good name might be a particularly important issue for women of ethnic minorities (Koss & Hoffman, 2000), making the disclosure of violence nearly impossible.

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It has been suggested that the way a question about violence is addressed in a survey further significantly affects the disclosure of violence by family members (Milhalic & Elliot, 1997; Walby & Allen, 2004). Incidents between intimate partners, such as pushing the partner or using humiliating words, might not be considered illegal or abusive by the people involved, as is often the case with emotional abuse, resulting in the exclusion of such acts in any report. Victims who are unaware that what they are experiencing is a crime are unlikely to report it as such (Walby & Allen, 2004). Milhalic & Elliot (1997) suggest that if questions about IPV are worded in a general criminal behaviour context the partner violence often goes undetected whereas it is more readily disclosed in the context of marital discord. Similarly, gender and group differences in reporting present additional difficulties for researchers and clinicians alike. According to Walker (1999) women tend to report both intentional and unintentional acts whereas men report only intentional acts of aggression. Both men and women may justify, normalise and minimise the abuse in different ways (WAFE, 2006). Common excuses revolve around the use of alcohol or drugs during the time of an incident. Stress, frustration or psychological problems are used as contributing factors to temporary reduction of the capacity for self control (Bograd, 1988). These justifications may serve the purpose of protection. This behaviour helps survivors to keep the relationship in balance or the environment stable for the perpetrator (Walker, 1981). Justifications further help hide the possibly considered shameful experience of abuse and serve the purpose of explaining the experiences to others. Excuses or justification may also lead to underreporting by survivors as intentional acts of abuse are minimised to situational and excusable incidents rather than criminal behaviour. Perpetrators rarely understand their

behaviour as deviant. Men frequently minimise and deny incidents of abuse, blame their partners for it, or justify violence in the hope of achieving a positive outcome (Bogard, 1988). Men are also thought to frequently underreport violence (Anderson, 1997). Mihalic and Elliot (1997) claim that members of the 'working class' are most inconsistent in reporting domestic violence. Differences in reporting also exist among diverse ethnic groups. For various reasons, including fear of minimal or absent cultural understanding by professionals and the wish to protect their partners from mistreatment by the law enforcement of the main culture, women belonging to an ethnic minority might have additional and unique problems reporting their experience to members of the main culture (Koss & Hoffman, 2000).

Because of differences like those described above it is difficult to identify exactly how many individuals are affected by domestic violence. Mistakenly, it might be believed that domestic violence is therefore not a serious problem and that interventions currently available are sufficient. Differences in reporting, and resulting obstacles in pinpointing what exactly the most beneficial resources can be, also make it problematic for funding agencies to allocate sufficient financial resources to the appropriate sites to help survivors of IPV.

1.1.3. Causes of Intimate Partner Violence

Although domestic violence has existed for centuries it did not receive the focused attention of researchers until the 1970s. Particularly during the past two decades, professionals have attempted to illuminate the causes and underlying factors of violence between intimate partners who commonly are believed to love and care for one another (Tolan, Gorman-Smith & Henry, 2006).

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With the advent of domestic violence research, many scholars have suggested placing the phenomenon within the realms of several theoretical foundations or models. Generally, theoretical foundations through which domestic violence has been understood can be grouped into basic categories (Seeley & Plunkett, 2002). Firstly, individual-focused models attempt to find causes of violence within the individual perpetrator or victim. Analysis of domestic violence from this perspective examines an individual's psychological/biological/genetic factors as the most prominent contributors to the use of aggression in relationships. Secondly, sociological and socio-cultural models see domestic violence as a learned behaviour and a result of interactions between family members that have been passed from one generation to the next (Gelles, 1987; Strauss, Gelles & Steinmetz, 2003). Family Systems Theories, Feminist Perspectives and Social Learning Theory for example focus on IPV in relation to social structures such as gender, ethnicity, or social status. Norms for acting in society are based on underlying beliefs shared by most people and traditional views concerning roles and behaviours. Feminist Theory particularly focuses on social attitudes as well as gender inequalities in society as catalysts for violence between family members. According to this framework, tolerance of any kind of violence and therefore the justification of the use of aggression is apparent in many cultures (Seeley & Plunkett, 2002).

The feminist perspective is the underlying structure in much of the domestic violence research and often informs the work with survivors in refuges or support groups. From this framework, the roots of the problem, namely tolerance and even support of violence against women, lie within a male dominated (patriarchal) society (Dobash & Dobash, 1998; Pagelow, 1992). The

focus on patriarchy, the entitlement of dominance of the male over the female, and the resulting inequality between genders is the reason for the existence of violence within the family, and particularly the violence between intimate partners (Murphy & Meyer, 1991; Seely & Plunkett, 2002; Walker, 1986). Historically, a wife was the husband's responsibility, a position which allowed him to rule and control women in the family (Babcock, Waltz, Jacobson & Gottmann, 1993; Walker, 1986). Physical force or punishment were not only rationalized but also supported by institutions such as the state or the church. Although it is assumed that modern, western society has made great progress in its strive for equality between the sexes, male dominance is still apparent in many aspects of every day life. Male dominance along with the glorification and tolerance of violence toward women is visible for example in advertisements, in popular music, and in film (Hage, 2000; Hanneke, Shields & McCall, 1986). Commitment to gender specific behaviour is still encouraged and valued in boys and girls (Dobash & Dobash, 1998).

Support for feminist theory of domestic violence can be found in the unequal proportion of physically violent acts between intimate partners. According to recent international statistics, 85% of survivors of domestic violence are women (Walby, 2004). Women survivors also make up 35% of patients in emergency rooms (Pagelow, 1992) indicating the possibility that even though aggression might be used as a strategy to dominate by both males and females, women are more frequently victimized and thereby seriously harmed more often than men (Browne, 1993; Straus, Gelles & Steinmetz, 2003). Early research on IPV often attempted to explain the phenomenon by placing blame on the victim. According to Snell, Rosenwald and Robey (1964) a husband's violence served as

a temporary measure to relieve him from feeling ineffective as a man and to help his wife manage the feeling of guilt arising from her hostile behaviour towards him. Wife abuse has been seen as the fulfilment of the “masochistic needs of the wife” and is therefore necessary to maintain the couple’s equilibrium (Snell, Rosenwald & Robey, 1964, p.110). Victim blaming however is still cited as a problem and a barrier to empowering survivors of violence (Browne, 1993; Pagelow, 1992; Seeley & Plunkett, 2002). A closer look at reactions of institutions and individuals who come into contact with survivors reveals that in cases of IPV or sexual assault, great weight is often given to the claims and explanations of the male perpetrators while blame is placed on the seemingly passive victim (Kelly & Radford, 1998). Blame is embedded in the label of “victim” itself (Ituarte, 2007) and many professionals feel that this label inappropriately implies some control from the woman over her experiences. Even health care workers such as midwives still engage in stereotyping and victim blaming (Browne, 1993) and believe that women are in charge and in full control of their lives as well as their relationships (Cleary, 2006). It is not surprising that until recently, service providers strongly believed that treatment efforts should be directed at the woman in order to save the relationship (Walker, 1986). As a consequence, the possibility of receiving the stigma that has generally been placed on wives abused by their husbands, is still very much a valid concern for many women in a violent situation (Koss & Hoffman, 2000). Feeling ostracised by individuals in the community or even by family and friends may contribute to already existing feelings of shame and guilt.

However, none of the theories applied to the phenomenon of domestic violence is able to fully explain all of the various forms of violence in the home.

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Although many feminists believe that every man has the propensity for violence, not every man abuses his intimate partner, leaving the question of why are some men violent and not others (Neale, 2002)? Further, not supporting feminist theories is the fact that intimate partner violence can be perpetrated by women in same sex relationships as well as heterosexual relationships. In order to gain a deeper understanding of the phenomenon of IPV a consideration of a combination of diverse theoretical viewpoints might be beneficial. Edelson (2000) has proposed an ecological perspective when looking at domestic violence and its causes. Accordingly, an individual is impacted by several factors and behaviour is shaped through interactions of people and their social environment. The development of each person is influenced by the organization within the individual (Ontogenic System), interactions with family, friends and other individuals close to the person (Microsystem), as well as the interaction between those individuals (Mesosystem), actions of policy makers (Exosystem), and finally the influence of cultural beliefs and attitudes (Macrosystem). The Macrosystem governs the expectation of normal behaviour of individuals within a society and might therefore be of significant interest in the explanations of IPV from a feminist perspective. The ecological approach has been applied to explaining individual, relationship and contextual risk factors for violence within the family (Tolan et al., 2006).

1.1.4. Risk Factors for Violence

Until recently, prevention efforts were frequently directed towards the survivor rather than the perpetrator of violence, causing past and present researchers much time and resources to find predisposing factors that could influence individuals to

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become victims of domestic violence. Research has to a great extent focused on what makes women more vulnerable to violence (Walker, 1986). Factors under investigation were unassertiveness, emotional dependency, cognitive deficits, and particular attitudes (Seeley & Plunkett, 2002). Despite numerous attempts, no one distinct profile has been found to fit the typical domestic violence victim/survivor. There is no strong evidence to support the belief that some women might be more likely to experience abuse than others (Ganley, 1995; Seeley & Plunkett, 2002; Tutty Bidgood & Rothery, 1993). According to Browne (1993) “empirically, characteristics of the man with whom the woman is involved are better predictors of a women’s risk of becoming a victim than are characteristics of the women itself” (p. 1079). A man’s behaviour seems to differentiate violent from non-violent couples (Babcock et al., 1993).

IPV happens to individuals in all age groups, of every gender, culture, religion, education, socio-economic status and regardless of any personality characteristics (Ganley, 1995; Koss & Hoffman, 2000). Numerous risk factors including ethnicity, physical and mental disability, illness, substance abuse, history of domestic violence, and low self-esteem have been examined in order to understand when and how IPV might become more likely. Although the outcomes of many research studies indicate mixed results, it appears that some general contributing risk factors have been identified. The two biggest risk factors revolve around gender and age. Additionally, socio-economic status seems to contribute to the likelihood of violence in families as, statistically, more cases of domestic violence are reported in families of lower socioeconomic status (Wilt & Olson, 1996). Other factors such as ethnicity and cultural attitudes, substance misuse, health status, or family history have been thought to correlate highly with violence

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but are still under debate and might not be the most significant predictors (Hotaling & Sugarman, 1986) or only influence IPV in relation with other factors such as socio-economic status.

The single biggest risk factor for any type of violence is gender (Koss & Hoffman, 2000; Walker, 1999). Regardless of culture or geographic area, females are victimized at a much higher rate than males (Rennison & Welchans, 2000; Walby & Allen, 2004). Although domestic violence has many forms and can be directed at any family member, 85% of those affected are women (Walby & Allen, 2004). Women are more likely than men to experience more severe injuries in fights with partners (Koss & Hoffman, 2000), are more likely to fear for their lives and are more gravely impacted by the experience (Straus et al., 2003).

An additional risk factor for IPV is age. Domestic violence affects individuals of all ages, however, young women seem to be significantly more likely to experience domestic violence than older ones (Rennison, et al., 2000; Walby & Allen, 2004; Edelson, 2000). As several studies point out, women between the ages of 20 to 24 are most at risk for violence from their intimate partner compared to any other age group. (Rennison, at al., 2000; Walby & Allen, 2004; Wilt & Olson, 1996). It has been suspected that younger men appear to be quicker to use and be more tolerant of violence in general as well as in a relationship (Walby & Allen, 2004). Also, marriages tend to be more violent in early stages, which might support the finding that predominantly younger women are affected by it (Edelson, 2000; Wilt & Olson, 1996).

A third but still controversial predictor of violence is socio-economic status. Various researchers support the idea that domestic violence is predominant in families of lower socio-economic status (Grana, 2001; Wilt & Olson, 1996),

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between homeless individuals (Toro et al., 1995) or in families where the victim/survivor is unemployed, inactive or has no access to the family funds (Walby & Allen, 2004). Most researchers agree that the likelihood of violence increases in families with lower income and that family violence is slightly more common among blue collar workers and the unemployed (Ganley, 1995; Neller et al., 2005). Within the framework of the Ecological Approach to Domestic Violence, stressful life situations such as unemployment or underemployment, being forced to live in violent communities because of lack of resources, impact both perpetrators and survivors at individual levels, and in combination with lack of resources and support may greatly contribute to the use of violence within relationships (Edelson, 2000). In this debate it should also, however, be considered whether unemployment, inactivity and lack of financial support are antecedents or consequences of domestic violence and part of the control tactics used by the perpetrator. Inconsistencies between research reports still exist and leave the negative correlation between socioeconomic status, income and domestic violence in question (Grana, 2001). Although unemployed women might seem to be a likely target for abuse, violence is also reported to be of greater prevalence in relationships in which the woman works in higher paying jobs or has a higher education than the perpetrator (Babcock et al., 1993). It has been suggested that women with a higher status might be a more likely target of abuse because of perceived insecurities by their partners. In this case, violence might be used in an attempt to reassert the authority, or re-establish the power base of the 'head of the household' (Gelles, 1987; Murphy & Meyer, 1991). This idea of "Resource Theory" was proposed by William Goode in the 1990s and is thought to explain violence in occupationally and educationally incompatible relationships

(Anderson, 1997). It is possible however, that IPV is more likely to be reported by individuals with a lower socioeconomic status.

The notion of a 'cycle of violence' or the idea that experience of violence in childhood breeds greater tolerance for violence in adulthood has been an ongoing debate. According to Social Learning Theory, behaviour is learned by watching the interaction and behaviour of others as well as the outcome of that behaviour. When applying the theory to understand domestic violence it is suggested that children from violent homes 'learn violence' and are at a much higher risk of perpetrating or experiencing violence themselves (Gelles, 1987). Support for the idea that witnessing and experiencing aggression between parents while growing up influences the views and tolerance of violence in adult relationships exists (Hotaling & Sugarman, 1986; Marshall & Rose, 1988; Shir, 1999; Smith Stover, 2005; Walker, 1999). There is much evidence to indicate that exposure to violence in the childhood home seems to make men more likely to resort to violence in their own families (Edelson, 2000; Ehrensaft, et al., 2003, Koss & Hoffman, 2000) and makes women more likely to be physically victimised by an intimate partner in adulthood (Desai, Arias, Thompson & Basile, 2002). In a study of the correlation of childhood abuse and re-victimization in adulthood, Coid and colleagues (2001) found that incidents of abuse do not occur in isolation. Childhood exposure to violence, i.e. having experienced physical and sexual abuse as a child, seems to place women at a higher risk of re-victimization in adulthood. When childhood abuse was severe, experiences of severe violence later on were also more likely. Participants who experienced multiple forms of abuse in childhood were found to suffer numerous incidents of maltreatment in adulthood (Coid et al., 2001). Witnessing, rather than experiencing violence

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between parents in the childhood home is regarded as a risk marker for both men and women (victims and perpetrators) with some consistency (Hotelling & Sugarman, 1986). Some researchers employ the theory of assortative mating, the idea that individuals generally find partners with similar traits. According to this theory women who grew up in abusive and violent homes tend to marry individuals who grew up in similarly violent homes (Pollak, 2004).

Nevertheless, not all studies support the idea of an actual cycle of violence. Some argue that being the victim of childhood abuse, experiencing violence directed at oneself, does not necessarily directly lead to perpetrating physical violence as an adult (Bevan & Higgins, 2002; Neller et al., 2005; Pagelow, 1992) and it does not make women more likely to seek out a violent relationship (Neale, 2002). According to Pagelow (1992) only 1 out of 3 survivors of childhood abuse will also be violent against their own children. Some researchers have suggested that a combination of several risk factors, such as the variety of trauma experienced, the presence of conduct disorder and alcohol abuse, might negatively impact adult experiences (Bevan & Higgins, 2002; Neller, 2005). It is important to note that not all perpetrators come from violent homes and many survivors have not witnessed domestic violence in the family of origin.

Although isolation has previously been thought to be a weak predictor for IPV (Anderson, 1997), some researchers identify social isolation as a further risk factor for violence in the relationship (Edelson, 2000). Women who live in inner-city areas are at a higher risk to experience IPV, sexual assault, and stalking as compared to women in urban and rural communities (Walby & Allen, 2004). Residents of inner-city areas are more likely to live anonymously without other

family members or even friends nearby, maintaining isolation and a lack of access to resources. Frequent moving due to lack of work might be a further contributing factor (Grana, 2001). It has been shown that women who had no friends or relatives who can provide them with direct help (such as making accommodation available to them in case of an emergency) also experience aggression in the home at a greater rate (Walby & Allen, 2004). Isolation may again however, be a tactic employed by the perpetrator, making it a consequence of domestic violence rather than a pre-existing risk factor.

Further debate exists around the influence of alcohol and drug abuse as a risk factor for domestic violence. There seems to be significant overlap between substance abuse and domestic violence (Edelson, 2000; Fals-Steward, Leonard & Birchler, 2005; Field, Caetano & Nelson, 2004; Humphreys, Regan, River & Thiara, 2005). Although no clear causality between alcohol or other drugs and violence in the family has been established, a large number of survivors and perpetrators are found to have substance abuse problems as well (Langhinrichsen-Rohling, 2005). Alcohol use is associated with IPV particularly in hostile and verbally aggressive couples (Fals-Steward et al., 2005). Research suggests that alcohol use in cases of IPV is associated with more severe injuries and more frequent abuse (Stalans, 2007). Humphreys et al. (2005) suggest that survivors use alcohol and other drugs in order to cope with their traumatic experiences. Further, partners in an intimate relationship seem to use substances in similar ways. In light of assortative mating theory researchers have investigated the role of relationship concordance in terms of mental health problems and alcohol/substance abuse (Low, Cui & Merikangas, 2007). Although little evidence exists of similar rates of mental health problems between partners, substance use

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disorders are consistently highly concordant (Low et al., 2007). It is not yet clear what role alcohol use or dependence plays in placing women at an additional risk of being violated or whether substance abuse is used as a form of self medication by individuals who have experienced violence. However, the high correlation between IPV and alcohol use is an important one.

Cultural beliefs and attitudes seem to be an important factor when trying to understand the connection between drug use and domestic violence (Field, Caetano & Nelson, 2004). It is theorized that men often use the effects of drugs as an excuse to act in otherwise unacceptable ways because they are generally known to make a user uninhibited and more prone to aggression (Field et al., 2004). Some men believe that it is just as tolerable and justifiable to misuse substances as it is to control and hit ones wife (Humphreys et al., 2005).

Walby and Allen (2004) suggest a correlation between poor health and IPV. Women who have experienced severe abuse appear to be in poorer health and vice versa. Poor mental health, including anxiety and depression, has been thought of as a possible contributor to domestic violence as some women report seeking mental health services before the onset of an abusive relationship (Cascardi et al., 1995). Because of the difficulty of measuring these constructs, it is not clear whether poor health or disability causes women to be more vulnerable to domestic violence or whether domestic violence contributes to a decrease in women's well-being. Similarly, pregnancy as a cause of increased risk for incidents of violence has been considered. Wilt and Olson (1996) report inconsistent findings in the literature about the prevalence of violence in pregnant women. While some anecdotal evidence suggests that pregnant women might be at a lower risk for abuse, several studies suggest that pregnant women are more

likely to be abused (Gelles, 1987; Jalinski, 2004). Jalinski (2004) reports that there has been supporting evidence for both pregnancy as a risk factor for increased violence as well as pregnancy being a time of respite for women in violent households. Pregnancy can be a time of increased stress, especially for first time parents and parents of lower socio-economic status, and might therefore also be a time of increased frustration and aggression (Gelles, 1987). Women seem especially likely to be abused during pregnancy if the pregnancy is unintended or sooner than planned or when the father does not want the baby. Some interpret an increase in violence during these times as an indication of a father's insecurity and jealousy towards the unborn child who reserves the mother's attention. An unintended pregnancy could be a factor beyond his control resulting in anger and resentment (Jalinski, 2004). However, many studies recently conducted have not found a significant increase in risk for pregnant women, indicating that women are just as likely to be abused during pregnancy as during non-pregnancy (Jalinski, 2004) and it is thought that 40 to 60% of victims are also abused while pregnant (Humphreys et al., 2001).

Along with the factors mentioned above, individual traits (psychopathology such as personality disorders and low self-esteem) (Dutton & Bodnarchuk, 2005) as well as relationship factors including perceived support and relationship satisfaction (Langhinrichsen-Rohling, 2005), play an important role in the tolerance for and use of violence (Field et al., 2004; Tolan et al., 2006). Not one single factor might be responsible for the existence of IPV but rather a combination and interaction of several factors in specific situations contribute to the perpetration and experience of abuse (Carden, 1994). The risk markers proposed by previous researchers and discussed in the previous section should be

considered as factors contributing to IPV and in light of the imbalance of power between partners form a basis for the perpetration of IPV.

1.1.5. Dynamics of Violent Relationships

Some patterns and recurrent themes seem to emerge when examining abusive relationships across all socioeconomic or cultural levels. These themes or patterns focus not only on the use of physical force but also encompass the use of jealousy and possessiveness, economic pressures, threats, destruction of property, emotional abuse (Cascardi et al., 1995; Hilberman & Munson, 1997) and social isolation (Gelles, 1987). Often in combination with periods of kindness, gifts, and promises, these aggressive patterns are rarely random but seem to function as purposeful tactics of control of one partner over the other (Ganley, 1995; Walker, 1986). Although it is clear that each relationship is complex and the use of violence influenced by a number of factors, an identification and understanding of common patterns might be an important informant to therapeutic interventions with both perpetrators and survivors of domestic violence.

A certain level of approval for violence exists in most societies (Straus et al., 2003). To this day, some forms of violence are often considered, consciously and unconsciously, as normal and helpful, even necessary and deserved, especially in the upbringing and teaching of children (Gelles, 1987). This ‘normal violence’ is often part of a family’s routine, particularly when caregivers believe that a message cannot be communicated to children in any other way (Gelles, 1987). One important common denominator of abusive relationships is the unequal balance of power. Patterns of abuse can be physical, sexual emotional/psychological, and/or economic. More than one type of abuse is

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frequently present and verbal abuse, threats and rape are common combinations used in severely aggressive relationships (Browne, 1993; Houskamp, 1994, Pagelow, 1994). It is believed that violence serves to establish or maintain power to which the perpetrator feels entitled and that women are expected to adequately fulfil the role of wives and mothers. Failure to do so is cited as a common trigger or provocation of violence between partners (Dobash & Dobash, 1998). Further triggers reported include not obeying the man, arguing back, not caring adequately for the family or the home, and refusing sex (Krug et al., 2002). In many, and particularly in developing countries, individuals believe that it is the man's right to discipline his wife, if necessary by physical force (Krug et al., 2002). Men justify, rationalise and support the use of violence and by defending traditional attitudes (Dobash & Dobash, 1998).

Babcock and colleagues (1993) suggest that increased violence is associated with the perpetrator's lower perceived power, particularly decision making power. As mentioned previously, women with greater status careers/jobs, better salaries, and higher education seem also more likely to experience psychological and/or physical abuse by their male partners (Babcock, 1993; Murphy & Meyer, 1991). Walker (1981) further finds that personal factors, such as low self-esteem of the perpetrator, along with mutual dependence and the belief that each is necessary for the other partner's well-being, are often displayed by partners in an abusive relationship.

Aggression can also serve as means to resolve conflict (Loseke, 2005). Ineffective communication skills or a lack of verbal communication seem common in distressed families. Babock et al. (1993) propose that violence is most likely used when aggression is perceived by the perpetrator as the only effective

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way to achieve his intentions and when he was not able to negotiate or coerce a partner into his intentions by any other means. By perceiving that 'there was just no other way', the use of aggression can be excused or justified by the perpetrator. Research has shown that less (verbally) communicative men are also more abusive towards their female partners while lower communication skills of the woman were also correlated with greater use of psychological abuse (Babcock, 1993), suggesting that deficits in verbal communication skills by either partner might therefore place a couple at greater risk for violence.

In families where aggression is used as a form of communication in resolving conflict, other reasons for violence might play an equally important role. Aggression may be used by the victim in an attempt to protect herself or her children in anticipation of violence by the perpetrator (Gelles, 1987). An ongoing debate exists about the mutuality of violence between partners. Men are injured by women in violent attacks, however, in mutual combat women often suffer greater injuries and more serious consequences more often than their partners (Ehrensaft, 2007; Pagelow, 1992). Both partners can be aggressive, often for reasons such as self-defence or protection of children, however most researchers have established that in heterosexual relationships men are still the primary perpetrators of violence (Browne, 1993; Johnson & Ferraro, 2000). It is clear that despite common patterns and themes the dynamic of abusive relationships is a complex one. A possible distinction between the types of abusive relationships might be necessary for furthering an understanding of IPV and therefore of developing effective prevention policies (Johnson & Ferraro, 2000; Neale, 2002).

In an attempt to understand the phenomenon of IPV, several researchers have found it helpful to further differentiate between types of violence and

situations that make abuse more likely. Johnson and colleagues (2000) have proposed four types of abusive relationships, labelled Common Couple Violence, Intimate Terrorism, Violent Resistance, and Mutual Violent Control. ‘Common couple violence’ is not connected to a pattern of control or the result of a power imbalance. This pattern of IPV might arise out of a specific argument and may involve one or both partners lashing out. According to Johnson and Ferraro (2000) this type of violence might be commonly found in samples from the general populations and might therefore contribute to the debate about equal contributions to combat by both genders. ‘Violent resistance’ is the term used by the researchers for less common relationships in which one partner (in many cases the woman) use violence as a form of self-defense. ‘Intimate terrorism’ on the other hand might be the most common form of abuse experienced relationship by women in refuges. It is also this type of violent relationship which is seen most often by police and in the courts. Here, power and control are the main motives and violence can escalate over time. In this type of relationship several forms of abuse might be employed and can more frequently result in serious injury. In the least common ‘Mutual Violent Control’ relationship two “intimate terrorists” fight for power and can both be equally controlling and violent.

1.1.6. Perpetrators of Intimate Partner Violence

It has often been suggested that perpetrators, like individual abusive relationships, differ to some extent (Ganley, 1995; M. P. Johnson, 1995; E. Walker, 1999). Similarly to women who suffer IPV, men who perpetrate violence constitute a diverse group and the heterogeneity of perpetrators has been well established (Johnson et al, 2006). This notwithstanding, sexually and physically

violent men share commonalities such as antisocial tendencies, poor social skills and lack of responsibility, affective dysregulation, impulsivity and alcohol abuse (White, McMullin, Swartout, Sechrist & Gollehon, 2007). Common personality characteristics of men who abuse their partners include higher scores on questionnaires investigating narcissistic, avoidant, antisocial, angry and impulsive personality traits (Scott, 2004). Men who are sexually aggressive further tend to report a lower sense of self-worth and higher levels of psychopathic traits than non-sexually aggressive men (White et al, 2007). Antisocial behaviour and depression, particularly in combination with alcohol use, has not only been associated with IPV but also with more frequent and severe forms of domestic violence (Fals-Steward et al., 2005) and are considered to be mediating variables between childhood experiences of violence and perpetration of violence in adulthood (Downs, Smyth & Miller, 1996; Ehrensaft, 2007).

As with victims of violence, much time has been spent in finding groups to fit perpetrators of domestic violence. Although several categories for violent men exist, the most well-known typology for batterers has been proposed by Holtzworth-Munroe and Stuart (1994). Abusive men typically fit into one of three separate groups of perpetrator types labelled 'family only violent', 'Dysphoric/Borderline' and 'generally violent/antisocial' (Holtzworth-Munroe & Stuart, 1994). These three groups were identified on differing dimensions of violence such as severity and generality of violence and personality disorder or psychopathology. Family-only batterers show low severity and generality of violence as well as low criminal involvement. They may have deficits in social skills within their relationship (Scott, 2004) and are least likely to report psychopathology and substance use disorders. Aggression might be used as a form

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of conflict resolution rather than a way to gain power. It has been suggested that violence in this group remains at a low-level due to their positive attitudes towards women and negative views on violence might contribute to keep the aggression from escalating (Johnson et al., 2006). Dysphoric/borderline offenders tend to be generally violent, report high levels of depression and anger and moderate levels of substance use. Men in this group are more likely to report parental violence and abuse in childhood, are more insecure in close relationships and have fearful attachment style. These men have been suggested to display borderline personality characteristics, are more likely dependent and jealous, and tend to turn to violence when they perceive abandonment by the partner (Johnson et al, 2006; Scott, 2004). Men in the generally violent/antisocial offenders group not only engage in severe physical and sexual abuse but also tend to hold high levels of criminal involvement and violence outside the home. Men in this group are more likely to have antisocial personality characteristics, more often report alcohol and substance abuse problems, have experienced higher levels of abuse and parental violence and hold attitudes that support violence and hostility toward women (Johnson et al., 2006; Scott, 2004). It is often assumed that violence escalates in severity and frequency over time, however this might not be true for all batterers. The traits identified by Holtzworth and colleagues also tend to remain constant over time (Holtzworth-Munroe et al., 2003).

Other well-known categories for abusive men include the subtypes of pit bulls and cobras (Jacobsen & Gottman, 1998). “Cobras”, are a group of perpetrators characterized through emotional or internal coldness. They do not seem to experience an increase in heart rate or other changes in physiological measures during violent attacks. “Pit-bulls”, on the other hand, are often

described as dependent and needy as well as very emotional during attacks (Johnson & Ferraro, 2000). The understanding of the different types of perpetrators has informed approaches to batterer intervention programs and continues to aid in the development of prevention efforts.

Regardless of differences in definition and conceptualisation of IPV and the lack of true estimates of its prevalence, it is clear that the phenomenon of violence between intimate partners is a multifaceted one, which is neither easily illustrated nor summarised. Violence within relationships takes on many forms and much research remains to be done in order to understand clearly the causal relationships and risk factors for domestic violence. Age, socioeconomic status, substance use and aggression in the family of origin might contribute individually to abusive relationships but also often work in combination to heighten the risk of abuse. Although numerous risk factors have been established it is important to consider factors such as low socioeconomic status, isolation, poor health, and substance abuse as possible results of domestic violence or control tactics employed by the perpetrator as well as antecedents for domestic violence. An insight into the dynamics of abusive relationships, including motives and perceived reasons for violence, is not equal to justifying or excusing IPV, but is a further step in creating appropriate and successful interventions. The immense amount of research and discussion regarding interpersonal and family violence has contributed to a greater understanding and awareness of the issue not only amongst individuals who work with perpetrators and survivors but also in the general public. Violence against women is an ongoing problem with far-reaching consequences and despite increased social activism and vast research is still nowhere near extinction. There is need for future research to address remaining

inconsistencies so more accurate numbers can be determined and effective steps can be taken to improve prevention efforts and interventions for those affected by violence. Regardless of reporting differences, domestic violence is not trivial, normal or insignificant but an immense and wide-spread problem with grave consequences for victims. The development of new interventions and support for existing services to reduce the incidents of domestic violence but, just as importantly, to minimise the harm and negative consequences survivors are therefore crucial.

1.2 The Impact of Intimate Partner Violence

Women in abusive relationships experience violence repeatedly and often live with compromised safety and in constant fear of their partners (Cascardi et al., 1995). Historically, a large body of research has investigated the sole impact of physical violence on individuals. Although generally co-occurring, psychological/emotional abuse has previously not been evaluated in many research studies or has been deemed less important in light of the severe and prolonged physical abuse women experience. Only in the last two decades has similar attention been paid to the equally negative impact of psychological abuse (O'Leary, 1999). Early anecdotal evidence suggested that psychological abuse is perceived as possibly having an even greater negative impact on the well-being of survivors than physical abuse (Katz, Arias & Beach, 2000). A large number of survivors of IPV seems to consistently rate this type of violence as worse in effect than physical abuse (Aguilar & Nightingale, 1994; O'Leary, 1999). It is now clear that both psychological abuse and all forms of physical violence can have detrimental consequences for survivors.

1.2.1. Cause and Effect of Intimate Partner Violence

IPV is one of the most common causes of physical injury to women (Dwyer, Smokowski, Bricout & Wodarsky, 1995, Frauenhaus Greiz, 2004) and it's association with physical injury has been well established in the medical literature (Campell, 2002). The association between domestic violence and high rates of mental health problems has also received significant attention in the past decades. When compared to normative controls, women in domestic violence refuges experience significantly higher rates and more severe symptoms of Post Traumatic Stress Disorder (PTSD), regardless of frequency and severity of their abuse experiences (Humphreys et al., 2001) and are found to be significantly more depressed (Humphreys & Thiara, 2003). Dieneman and colleagues (2000) also point to a high prevalence of abuse in the history of women who have been diagnosed with depression in comparison with women in other clinical or normative samples. This strong association is commonly thought to represent a causal relationship, i.e. an indication that the experience of IPV results in mental health problems, despite the fact that this assumption might not have been fully investigated (Ehrensaft, 2007). Causality has been the focus of few research projects and still remains under debate.

Ehrensaft and colleagues (2006; 2007) have questioned this assumption of causality and investigated mental ill health as a both risk factor and a consequence of IPV. Drawing from a large sample in a longitudinal study, Ehrensaft and colleagues (2006) found that the experience of an abusive relationship indeed increased the risk for mental health disorders for women, but not for men. Specifically, women in abusive relationships were more likely to experience depression and PTSD (Ehrensaft, Moffit & Caspi, 2006; Ehrensaft, 2007). In men,

the association between IPV and mental ill health points to preceding psychopathology. As mentioned in section 1.6., men who abuse women are more likely to score higher on measures assessing psychological disorders or personality disorders (Murphy et al., 1994). Further, the risk for substance abuse, specifically marijuana dependence, increased for women who were involved in an abusive relationship as compared to women in non-abusive relationships (Ehrensaft et al., 2006). It was also found however that for both sexes mental health disorders did predict violence in early adulthood, at the ages of 24-26 (Ehrensaft, 2007). As young women are more likely to be affected by IPV and dating violence, this finding is an important one and might inform future interventions designed to combat violence between young people with mental health problems.

In one of the most extensive reviews of research investigating the prevalence of mental health problems among survivors, Golding (1999) establishes that women with a history of violence within an intimate relationship are significantly more depressed, have a higher prevalence of PTSD and are somewhat more likely to use alcohol or drugs than women in the general population. In her investigation, Golding uses several criteria to establish the type of relationship between the experience of violence and mental ill health. Her criteria include a review of the magnitude of the association, the permanence of the observation, the consistency of the association with actual passage of time, the dose-response relationship and possible changes in consequences following changes in hypothesised causes (Golding, 1999). Taking these important criteria into account, the results of her extensive meta-analysis concur with existing

research supporting the hypothesis that IPV clearly poses a risk factor for mental disorders.

In consideration of these key findings and with the awareness of mental ill health as a possible risk factor, the current study is based on the prevailing assumption that mental health problems are consequences of domestic violence rather than risk factors. The recognition and understanding of the diverse effects of abuse on survivors are crucial components in the development of successful treatment and often inform individual choices of intervention methods.

1.2.2. Effects of Intimate Partner Violence on Physical and Psychological Health

Nurses and health care workers are often the first individuals to witness the consequences of battering incidents when survivors present to emergency rooms and surgeries. Acute physical symptoms of a violent incident are likely to include broken bones, injuries to the abdomen, face, head, neck, back and breasts; bruises, contusions, abrasions, and lacerations (Campbell, 2002; Krug et al., 2002; Dutton et al., 2006). In many cases of IPV various forms of abuse are present and rarely does physical abuse exist without verbal and psychological abuse. A study by Campbell & Soeken (1999) revealed that up to 45% of women in physically violent relationships also experience sexual abuse. Gynaecological symptoms such as sexually transmitted diseases, vaginal bleeding, genital irritation, frequent urinary tract infections, and pelvic inflammatory disease are persistent problems experienced by survivors who experience sexual aggression in their relationships (Campbell, 2002, Krug et al., 2002). Similarly, documented adverse effects of abuse during pregnancy include miscarriages (Krug et al., 2002), abortions or low

birth weight infants (Campbell, 2002; Dutton, et al, 2006), fetal death by placenta abruption, foetal fractures, antepartum haemorrhage, or ruptured uterus (Dutton, et al, 2006).

It has been suggested that the response to psychological violence is equally diverse. Negative impacts of psychological abuse include first and foremost fear and anxiety (Carden, 1994; Gelles & Harrop, 1989; Gleason, 1993), confusion, depression (Kelly, 2004; O'Leary, 1999; Sackett & Saunders, 1999), cognitive distortions as well as negative health perceptions and behaviour such as substance abuse (Kelly, 2004). Psychological abuse is also a significant predictor of low self-esteem and low self-efficacy, and is thought to amplify symptoms of PTSD (Arias & Pape, 1999). However, in many cases of IPV physical and psychological violence coincide, making a distinction between its independent effects difficult. It is clear that both physical and psychological abuse have far reaching consequences.

Generally, psychological reactions to experiences of all forms of IPV encompass shock, confusion, feelings of helplessness (Gleason, 1993), inadequacy and guilt (El-Khoury et al., 2004; Walker, 1981). Further commonly cited consequences of domestic violence include symptoms of PTSD (Golding, 1999; Housekamp, 1994; Saunders, 1994; Wilkie, 2001; Woods, 2005) depression, suicidal ideation (Dutton et al., 2006; Mitchell et al, 2006), eating disorders, anxiety and panic disorders (Carden, 1994; Gelles & Harrop, 1989; Gleason, 1993; Krug et al, 2002). As mentioned previously, survivors of IPV are also at increased risk for drug and alcohol abuse (Carden, 1994; Housekamp, 1994) or substance abuse disorders (Campbell, 2002; Golding, 1999; Gleason, 1993; Khan, et al, 1993). Both physical and psychological abuse can cause

cognitive distortions and are thought to negatively impact on a victim's sense of self, including self-esteem and self image (Krug et al., 2002, Kubany et al, 2004).

Physical and psychological consequences of abuse do not necessarily cease with the end of the abuse. Women who have experienced IPV frequently report high rates of chronic somatic complaints (Gelles & Harrop, 1989), breathing problems, hypertension, heart and blood pressure problems (Cascardi et al., 1995), headaches, insomnia, choking sensations, hyperventilation, gastrointestinal symptoms such as irritable bowel syndrome, muscle tension, and chest, back and pelvic pain (Campbell & Soeken, 1999; Campbell, 2002; Dutton et al., 2006; El-Khoury et al., 2004; Krug et al., 2002) and persistent headaches (Follingstad et al., 1991). Enduring problems might also include seizures (Campbell, 2002), as well as dizziness and fainting (Cascardi et al., 1995).

In a study of older patients in community care, Wolkenstein and colleagues (1998) have found that cognitive distortions are by no means short lived but rather impact negatively on an individual's long term functioning. Strong reactions to abuse including feelings of anger, frustration, hopelessness and helplessness, fear, confusion and dysfunctional cognitions about the self can be internalised. While many of today's older women might have lived with these thought patterns for most of their lives, possibly without the availability of support, the consequences of the abuse experience still influences current relationships with friends and family. The resulting fear and lack of trust in others might further contribute to social and emotional isolation while fostering dependence and feelings of powerlessness (Wolkenstein & Sterman, 1998).

Within the large variety of negative consequences, the most commonly cited psychological reactions to IPV are decreased self-esteem, depression and

symptoms of PTSD. Because these problems appear to be the most commonly experienced emotional difficulties by survivors, they will be of particular interest and the focus of this thesis.

1.2.3. Effects on Self-Esteem

The association between low self-esteem and abuse by a family member or partner has been recognised by professionals in the area of domestic violence (Aquilar & Nightingale, 1994). In recent decades, the negative relationship between intimate partner violence and self-esteem has been further established by numerous researchers (Arias & Pape, 1999; Aquilar & Nightingale, 1994; Carden, 1994; Campbell & Soeken, 1999; Gleason, 1993; Katz, Arias & Beach, 2000; Kelly, 2004). The experience of physical abuse, and particularly sexual violence, is thought to result in a less positive body image, which contributes greatly to low self-esteem (Campbell & Soeken, 1999). Factors related to the level of self-esteem include the type and frequency of abuse experienced. Not only physical violence but also psychological abuse has been suggested to contribute to negative self image and low self-esteem. Women who have controlling partners seem to display the lowest level of self-esteem (Aquilar & Nightingale, 1994; Sackett & Saunders, 1999). Additional psychological abuse tactics with detrimental and lasting impact on survivors include threats, ignoring, humiliation and ridicule (Aquilar & Nightingale, 1994; O'Leary, 1999). It has been suggested that self-esteem increases with the time period since the incident (Aquilar & Nightingale, 1994) and is moderated by external factors such as the support received from family and friends. Regardless, survivors of IPV are much more likely to suffer

from a negative and distorted perceptions of the self, even after the abusive relationship has ended (Wolkenstein & Sterman, 1998).

1.2.4 Effects on Depression

Similarly to negative self-image, the association between the experience of IPV and depression has been recognised by numerous professionals. Survivors of abuse suffer from depression at a much higher rate than non-abused women (Campbell & Soeken, 1999; Carden, 1994; Cascardi et al., 1995; El-Khoury et al., 2004; Gelles & Harrop, 1989; Gleason, 1993; Kelly, 2004; Miller, Veltkam & Kraus, 1997; Walby & Allen, 2004; Wolkenstein & Sterman, 1998). Women from lower socio-economic groups and minority ethnic women are particularly at increased risk for depression (El-Khoury, 2004; Hourly, Kaslow & Thompson, 2005). According to Walby and Allen (2004) 52% of women who identified themselves as survivors suffer from depression and emotional problems as a result of their experiences. According to other researchers the numbers of survivors suffering from depression is even higher, ranging between 77% (Follingstad et al., 1991; O'Leary, 1999) to 83 % (Waldrop & Resick, 2004). Rates of depression amongst women living in refuges are particularly high (Humphrey & Thiara, 2003)

The seriousness of these mental health difficulties should not be underestimated. Suicidal ideation has been cited in association with depression as a frequent consequence of IPV (Campbell, 2002; Hourly, Kaslow & Thompson, 2005; Walby & Allen, 2004) particularly so amongst ethnic minority women (Humphreys & Thiara, 2003). It is vital to recognise the strong influence of

gender specific violence on mental ill health. Violence against women contributes greatly to mortality and to life years lived with disability (Prince et al., 2007).

Many investigations have focused on factors that contribute to the symptoms of psychopathology for survivors. It has been established that the severity of depressive symptoms is positively related to the severity of the physical and psychological violence experienced by women (Cascardi, et al., 1995; O'Leary, 1999, Dutton et al., 2006) and the frequency of incidences of sexual violence (Campbell & Soeken, 1999). Survivors' depression is regarded as the common link between physical and psychological violence (Houry, Kaslow & Thompson, 2005). Cascardi and colleagues (1995) believe that lowered self esteem might contribute to vulnerability for depression for women in abusive relationships. Feelings of guilt and inadequacy that may further contribute to a decrease in self-esteem and depression might be exacerbated by a perpetrator's high and unrealistic expectations of his partner and her subsequent perceived failure to live up to them (Walker, 1981). It has been hypothesised that women who blame themselves for the abuse also suffer from more severe symptoms of depression (Cascardi & O'Leary, 1992). Whilst intuitively plausible, this idea has not been supported by research. The majority of women do not appear to blame themselves for the violence and the distribution of blame might not be an influence on depressive symptoms or self-esteem (Cascardi, O'Leary, Lawrence, & Schlee, 1995).

1.2.5. Posttraumatic Stress Disorder (PTSD)

The correlation between experiences of IPV and symptoms of PTSD has been suggested since early studies consistently found similar symptoms in women

who had experienced abuse (Woods, 2005). Only recently has this diagnosis been frequently applied to the difficulties experienced by survivors of domestic abuse. PTSD is a description of symptoms often experienced by individuals who have been subject to traumatic events causing extreme stress such as natural disasters, crime, or war. Such an event entails the experience of, or bearing witness to, physical aggression, a threat to one's own life or that of another person and the feeling of intense fear, horror or helplessness (Echeburua et al, 1997). The DSM-IV (APA, 1994) bases the diagnosis of PTSD on three main clusters or categories of symptoms. Firstly, high levels of arousal of the autonomic nervous system, such as anxiety, fearfulness, nervousness, and hyper-vigilance, must be present along with sleep and eating disturbances as well as attention difficulties. A further category of symptoms revolves around emotional distance to the trauma such as the avoidance of reminders of the event, emotional numbing, denial and dissociation. Re-experiencing the trauma through flashbacks, intrusive memories and/or dreams are part of the third cluster in the diagnosis of PTSD (APA, 1994; Van der Kolk, 2000)

Women in abusive relationships are faced with extreme stress and intense fear, the experience of harm or threat of harm to themselves, their loved ones or pets. Survivors have been thought of as 'victims of a disorder of extreme stress' due to the repeated and prolonged traumatising they experience (Miller, Veltkamp, & Kraus, 1997). They are commonly reported to experience flashbacks and intrusive memories (Saunders, 1994) as well as avoidance symptoms, which impact on the individual's ability to experience feelings (Woods, 2000). Quality of life is greatly affected by symptoms of PTSD, which commonly lead to

emotional withdrawal from others, avoidance of places or people, concentration difficulties as well as drug and alcohol abuse (Van der Kolk, 2000).

Elenore Walker introduced the term “*Battered Woman Syndrome*” (or BWS) in 1979 to describe the patterns of difficulties survivors face. In the past 20 years, BWS has frequently become a description for the symptoms that greatly impact on personal and sexual relationships, a woman’s body image and somatic concerns. Similarly to PTSD, the battered woman syndrome incorporates hyper-vigilance and avoidance features as well as intrusive memories. However, the battered woman syndrome additionally includes the experience of the cycle of violence and learned helplessness to the three symptom categories of PTSD (E. Walker, 2007). Walker’s (1984) cycle of violence is a three stage process, which distinguishes abusive relationships from non-abusive ones. The cycle begins with the tension building phase during which small incidences of abuse may occur and the pressure between partners builds toward an explosion. This stage is followed by a short phase of acute battering, while the next and last phase (loving contrition) involves apologies and promises of betterment from the perpetrator. Learned helplessness is the second component of Walker’s BWS. Learned helplessness is a phrase used for the “psychological paralysis that prevents some women from leaving their batterers” (Erickson, 2007, p. 71). Since the 1980s, the concept and term ‘Battered Women Syndrome’ has been used frequently in court cases to explain why some women felt compelled to kill their abusers. In recent years, BWS, including the notion of a cycle of violence and learned helplessness, has become the centre of debates. Although there is support for a similar progression in abusive relationships and the ‘cycling’ of violence, abuse may progress in a variety of ways for different women and not all survivors report the

experiences of a violence cycle as outlined by Walker. The idea that women may become passive and helpless in light of their experiences has been supported by a number of early researchers attempting to understand why women remain in abusive relationships (Peterson & Seligman, 1983). On the other hand, the ‘battered women syndrome’ also implies how a ‘normal’ woman stereotypically should face and react to abuse – fearfully, passive and weak. In that light, the concept has also opened the way for interpretations of what it means to be a ‘good women’, and what behaviour might constitute ‘bad women’ (Allard, 2006). In recent years, researchers and professionals have increasingly criticised the belief that women helplessly take the abuse and leave their situations unchanged, indicating misconceptions such as the idea that women must be in some way dependent on their abusers or are simply ‘martyrs’ (Anderson et al., 2002). More recent investigations show that many women actively engage in a variety of help-seeking behaviours and do not assume the role of passive victims in the abuse (Campbell, Rose, Kub, & Nedd, 1998; Erickson, 2007).

At this time, PTSD is commonly believed to be the most accurate description of symptoms and an appropriate diagnosis for survivors of IPV (Campbell & Soeken, 1999; Dutton et al., 2006; Gleason, 1993; Golding, 1999; Khan, et al., 1993). PTSD is highly prevalent in women survivors of domestic violence (Saunders, 1994; Seedat, Stein & Carey, 2005) and particularly those residing in refuges (Dutton et al., 2006). Recent studies reveal that up to 84% of women in refuges, who also reported more frequent physical, sexual and psychological abuse, experience symptoms of PTSD (Dutton et al., 2006; Saunders, 1994). These numbers are limited to those who were able to give information to researchers and are likely an underestimate. It is difficult to

establish how many survivors within the community suffer from symptoms of PTSD.

Depression and other types of anxiety disorders are believed to be co-morbid with symptoms of PTSD (Dutton et al. 2006; Seedat, Stein & Carey, 2005). As with depression and decreased self-esteem, the experience of symptoms of PTSD is influenced by the frequency and severity of physical violence (Woods, 2000; Van der Kolk, 2000). Particularly, the experience of sexual abuse, more severe and frequent physical abuse including the use of weapons, and childhood victimisation have been associated with symptoms of PTSD (Dutton et al. 2006). Further, the experience of threat or actual physical harm, and the presence of psychological abuse have been linked to severe symptoms of PTSD (Dutton et al. 2006). Impairment resulting from trauma is further compounded by length of traumatic experience and degree of social support (Van der Kolk, 2000).

1.2.6. Intimate Partner Violence and Treatment

Symptoms experienced after trauma, particularly chronic PTSD, will rarely cease without intervention (Echeburua et al., 1997). Many women might not choose to disclose their symptoms and might not seek treatment for fear of being labelled 'crazy', or out of fear of evoking anxiety by having to recall the abuse (Saunders, 1994). In the past, many survivors have been misdiagnosed as patients of schizophrenia or borderline personality disorder due to insufficient research into the effects of domestic violence and elevated scores on scales in psychometric tests such as the MMPI or MCMI II indicating schizoid or psychotic traits (Carden, 1994; Perez-Testor et al, 2007). As outlined, it has recently been acknowledged that symptoms of psychopathology are common and adaptive

reactions to traumatic experiences and would be similar in any person placed in an overwhelming situation (Woods, 2000). The development of psychopathology does not necessarily depend on the type of trauma experienced (Seedat, Stein, & Carey, 2005). Saunders (1994) believes that it is therefore important to educate survivors about symptoms and prevalence of symptoms such as PTSD.

The notion of a diagnosis and treatment of PTSD is important in consideration of the negative long- and short-term effects proposed by researchers (Dutton et al., 2006; Woods, 2005). Survivors of IPV suffering from symptoms of PTSD consistently report poorer general health than non-abused women (Dutton, et al., 2006). PTSD is not only a source of immense (emotional) distress for an individual, it is also responsible for long-term repercussions including a high prevalence of respiratory, cardiovascular, gastrointestinal and musculoskeletal problems as well as infectious diseases (Woods, 2005). Altered cortisol levels due to stress after trauma have been proposed to be a possible factor in the suppression of healthy immune functions (Campbell, 2002) while contributing to a rise in blood pressure (Dutton et al., 2006) and therefore heighten the vulnerability for various diseases (Woods, 2005). These stress related symptoms of PTSD may impact on both physical and psychological health years after the abuse has ended (Follingstad et al., 1990; Woods, 2000). It is assumed that PTSD can alter an individuals sense of self, coping and psychological functioning, for example the way threat is cognitively assessed, resulting in greater hostility towards others, which might further contribute to negative cardiovascular health (Dutton et al., 2006; Van der Kolk, 2000). As mentioned above, depression and low self-esteem further impact negatively on quality of life and can influence suicidal ideation. Both PTSD and depression negatively influence health behaviours such as

medication adherence, drug and alcohol abuse, as well as coping mechanisms important in dealing with a wide range of physical conditions (Dutton et al., 2006). Debilitating symptoms of both PTSD and depression contribute to failure to engage in preventative strategies which in turn increase the risk for re-victimisation. Many survivors of IPV have a history of violence in previous relationships or in the childhood home. Multiple traumatic experiences however affect the rate and capacity of recovery from trauma (Dutton et al, 2006) and further exacerbate psychological difficulties such as affect dysregulation, aggression against self and others, and negative self image (Van der Kolk, 2000).

1.3.1. Coping with Intimate Partner Violence

Survivors of domestic violence employ various ways of managing their lives, the abnormal circumstances and the high stress commonly associated with their relationships, particularly so if separation does not seem a viable option. Women may deny the violence or psychological abuse in front of others, make excuses and spend much time and energy in appeasing their partners and keeping a stress-free environment (Walker, 1981). Despite the previous assumption that women in abusive relationships are helpless, powerless and passive victims in their situation, survivors are often creative and effective in dealing with difficult conditions. Responses that may seem ineffectual, or even pathological by others serve a realistic and normative purpose of maximising safety and securing survival in crucial situations (Walker, 1991). Hence, survivors' reactions to abuse can be considered normal and adaptive responses to stressful situations. By manipulating the environment carefully women might not necessarily be able to

control the abuse but possibly the intensity, time and place for it (Gelles, 1987; Walker, 1981).

Adequate coping skills are crucial in mediating the negative effects of IPV on physical and psychological well-being. In the literature, coping is often separated into different approaches such as problem focused and emotion focused or approach versus avoidant coping. The literature also differentiates coping methods, including behavioural/cognitive coping (Moos, 1993; Parker & Lee, 2007; Waldrop & Resick, 2004). Emotion focused strategies include attempts to deal with the emotional impact of a problem and include daydreaming, praying, and hoping that the problem will cease with time, whereas problem focused strategies incorporate active attempts to change a situation or circumstances (Graham & Rawlings, 1991; Moos, 1993). Coping capacity includes specific skills in managing daily life such as obtaining support, problem solving, but also coping resources such as perceptions of self-worth, social support, and personal power (Nurius, Furrey & Berliner, 1992). The experience of physical and/or psychological violence as well as fear, threat, and environmental constraints seem to contribute significantly to impairments or constraints of various coping capacities (Carden, 1994; Walkdrop & Resick, 2004). Nurius and colleagues (1992) posit that survivors of domestic violence have significantly impoverished resources and are less able to mobilise effective responses following their experiences, making them more vulnerable to mental health problems. It has been proposed that survivors use maladaptive strategies, such as avoidant coping, to a much greater extent than women without the experience of violence (Mitchell et al., 2006; Wilkies, 2001) resulting in poorer psychosocial adjustment (Moos, 2004). Survivors tend to use emotion focused coping skills rather than problem

focused skills, particularly when abuse occurs more frequently and among those with more difficult experiences (Parker & Lee, 2007). The increased use of avoidant coping styles combined with a lack of institutional and social support are correlated with greater negative effect of the experience on women (Wilkie, 2001). The use of primarily emotion focused coping and engaging in avoidance coping has been linked to more distress and an increased risk of suffering from depression and PTSD among individuals who have experienced abuse (Parker & Lee, 2007; Waldrop & Resick, 2004). It has been considered that negative self-concept and perceived inability to influence events could be associated with cognitive avoidance strategies and feelings of helplessness (Moos, 2004). It has further been found that the experience of negative life events and more reliance on cognitive avoidance coping were predictors for depression and anxiety among women (Blalock & Joiner, 2000; Mitchell et al., 2006). In a study by Mitchell and colleagues (2006), survivors used less adaptive ways of coping such as confrontational coping, distancing (denying abuse, not permitting oneself to think about it or take it seriously), accepting responsibility (blaming and criticising self), and escape avoidance (overeating or using drugs) (Mitchell et al., 2006). Methods of coping with abuse frequently involve wishful thinking (Lewis et al., 2006) or managing intense emotions by using alcohol and/or prescription drugs (Dutton, 1992). Many women of ethnic minorities are likely to use prayer as a preferred and acceptable form of coping (El-Khoury et al., 2004; Mitchell et al., 2006).

Despite the idea that women in abusive relationships should be encouraged to use active, problem-focused coping, this approach might not be the most advantageous option for all survivors (Kocot & Goodman, 2003; Lewis et al.,

2006). It has been concluded that some women in abusive relationships tend to use confrontation, a strategy which may lead to an increase in abuse (Mitchell et al, 2006), and that active strategies exacerbate problems in an already difficult relationship (Lewis et al, 2006). When an active attempt to receive help is perceived as dangerous, limiting social contact and drawing on inner resources might be a more appropriate and even life-saving coping mechanism (Lewis et al, 2006). For survivors of intimate partner violence, coping might be situation specific and dependent on time and context (Goodman, Dutton, Weinfurt, & Cook, 2003). It has been proposed that women are sensitive to their perpetrators' actions and moods and choose from a variety of coping strategies that will maximise their safety while minimizing stress (Lewis et al., 2006; Mitchell et al, 2006). However, because these strategies might not involve challenging the partners' abusive behaviour, survivors may seem submissive or passive to outsiders. The choice of coping styles might seem inadequate to professionals, which might contribute to the assumption that women in abusive relationships lack problem solving skills (Waldrop & Resick, 2004).

The experience of violence reframes an individual's sense of the world, themselves and their relationship with others (Van der Kolk, 2000) but the ability to cope successfully with adverse situations is further dependent on numerous factors including social support (Bybee & Sullivan, 2005, Van der Kolk, 2000), history of abuse (Graham & Rawlings, 1991), community or neighbourhood violence (Bogat, et al., 2005), economic dependence, and access to community resources (Bybee & Sullivan, 2005). Not every woman who experiences IPV is negatively affected to the same extent as other women in similar situations. This does not imply the absence of immensely negative experiences but suggests that

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resiliency factors, adaptability to adverse situations, and external factors play an important part and may differ between individuals (Kennedy, 2005). Mediating variables include other life stressors (illness or disability and stress), social support and other resources (financial and community resources), other aspects of the relationship with the abuser, personality variables (attitudes, values and beliefs) and other's response to the abuse (Dutton, 1992; Humphreys et al., 2001). Psychological well-being after the experience of abuse might also depend on individual characteristics and preferred coping strategies (Parker & Lee, 2007), which could be impacted by differing cultural and ethnic backgrounds (Lewis et al, 2006). Several factors seem to impact such coping skills and techniques used by survivors of domestic violence. Frequency and severity of the violence a woman experiences, as well as childhood experiences of abuse are thought to influence coping capacity and the way adult relationships are managed (Parker & Lee, 2007; Waldrop & Resick, 2004). Coping strategies are also greatly affected by a woman's access to resources such as money, transport or a place to stay (Waldrop & Resick, 2004), as well as socioeconomic status (Carlson, McNutt, Choi, & Rose, 2002). Economically disadvantaged women frequently have greater difficulties accessing and receiving both resources and support (Mitchell et al, 2006). Prior experiences with coping strategies further influence the choice of methods used in the future. If calls to the police or disclosure of the abuse to friends or family have been met with negative responses, the strategy will be less likely to be used again (Waldrop & Resick, 2004). In order to stay safe in a complex situation women are likely to use the coping response thought to be most effective at the time (Campbell et al., 1998; Waldrop & Resick, 2004).

1.3.2 Why Women remain in Abusive Relationships

Long-term domestic violence, the consistent abuse lasting one year or more, has been indicated to affect between 9% and 30% of women (Wilt and Olson, 1996). Considering the detrimental consequences of abuse on survivors and the availability of help, it might be difficult to understand why women choose to remain with their abusive partners. Hence, reactions of women to their situation have been viewed by many as pathological or inappropriate. Only recently are certain reactions to abuse seen as normal coping mechanisms and attempts to stay relatively safe in extremely dangerous situations (Campbell et al., 1998; Moe, 2007).

The complex situation of IPV makes it difficult for many women to change the circumstances in which they find themselves. The majority of women experiencing violence already employ various strategies when seeking out help and protection (Allen, Bybee & Sullivan, 2004). It has been reported that women may attempt to leave up to seven times before separation is final (Goodkind et al., 2003). Safety concerns, alternative options, financial and practical resources, support from family and friends, experience with previous help-seeking attempts, and/or family and cultural expectations further play an important part in decision making of survivors (Langhinrichsen-Rohling, 2005; Waldrop & Resick, 2004). Reasons for remaining with an abusive partner as stated by survivors included fear of the abuser, lack of money, lack of places to go and probable homelessness (Anderson et al., 2003), barriers to seeking and receiving help such as little support from police, court, and/or medical professionals (Moe, 2007).

The decision to leave is often accompanied by realistic and warranted fears about the safety of the survivor herself as well as her loved ones (Logan &

Walker, 2004). Separation does not guarantee the end of abuse. Men who have become used to hitting women in the relationship are also likely to abuse her after separation (Pagelow, 1992). It has been reported that vulnerability to rape, serious injury or death, as well as the possibility of escalating violence, increases fivefold during the time of separation (Burman, 2007; Frauenhaus Greiz, 2004; Ganley, 1995; Pagelow, 1992; E. Walker, 1999). Men often continue to play a large part in the lives of women even after the relationship has resolved. Custody battles, joint custody or visiting rights, as well as the children themselves can be used as a further means to control the life of a woman by bargaining or using custody as a control tactic (Logan & Walker, 2004; Parnell, 2007), particularly when the fear of losing custody of her children plays an important part in a woman's decision to remain in an abusive relationship (Parnell, 2007).

The pattern of abuse might change both in frequency and intensity during the course of the relationship, and in many cases does not find its onset until the relationship has been settled, possibly after marriage, or during a time of additional stress such as pregnancy (Jalinski, 2004). Particularly in couples with later onset of abuse, striving for the ideal relationship, or the effort to keep the relationship as it used to be, may be a determining factor in a woman's decision to stay (Power, Koch, Kralik, & Jackson, 2006). The belief in love and promises also contributes to a decision to stay or to return after leaving (Anderson et al. 2003; Ganley, 1995; Walker, 1999). Further, Dutton & Painter (1993) posit that a particularly strong bond between partners, referred to as 'traumatic bonding', may be created by intermittent periods of kindness in an abusive relationship. This traumatic bond is also thought to contribute to the return to the abusive partner after an attempt at leaving has been made (Dutton & Painter, 1993; Graham &

Rawlings, 1991). According to Dutton & Painter (1993) negative memories of abuse are more likely to be forgotten after separation while the strong bond remains along with hope for betterment and reminders of positive aspects of the relationship (Dutton & Painter, 1993).

A further critical factor impacting a survivor's attempts to change is the response she receives from agencies and from individuals close to her (Grauweiler, 2007; Goodkind et al., 2003; Moe, 2007; Kocot and Goodman, 2003). Friends and family are frequently the first individuals approached for help by women in abusive relationships. Emotional support and particularly tangible support in the form of financial assistance or a place to stay are crucial in a woman's attempt to leave an abusive relationship (Goodkind et al., 2003). A supportive network of family and friends can not only lend the necessary support to leave an abuser or to go through with arrest and/or prosecution (Moe, 2007) but is also important for a survivor's well-being and quality of life (Goodkind et al., 2003). Bybee and Sullivan (2005) suggested that women with a lack of social support are more likely to attempt suicide while increased social support correlates with reduced depression, higher reported quality of life, and less risk for re-victimisation. Responses from family or friends that are judgemental, critical, blaming, and focused on preserving the family can be detrimental for a survivor, making the decision and attempt to leave even more challenging and stressful (Bybee & Sullivan, 2005; Moe, 2007). An effective response to a survivors' help seeking attempts by friends and family members is suggested to depend on several contextual factors including the number of times a woman has previously separated from the perpetrator, the couple's marital status, whether a larger

number of minor children are living in the home and the threat of harm to family members by the perpetrator (Goodkind, et al., 2003).

Although it has been established that the experience of violence and abuse is not justified by blaming the survivor, the responsibility for changing the abusive situation or leaving the partner is still often placed on the woman (Grauweiler, 2007). When approaching others about the abuse, women risk being blamed for the violence or for provoking the batterer (Campbell et al., 1998). In addition, many survivors experience shame and guilt, which might prevent them from speaking to others about the abuse. Frequently, attempts to disclose the situation to friends or family members are not productive (Moe, 2007). It seems that the more severe the violence, the more socially isolated the victim might be. In such cases less support is often available from friends when trying to discuss it (Waldrop & Resick, 2004).

Similarly, barriers to help seeking might be formed by service agencies. Difficulties and challenges when accessing, health care, victim and social services as well as housing and legal resources have been reported frequently (Logan & Walker, 2004; Moe, 2007) although health care professionals can function as important connections to legal and safety transactions for women (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Survivors have voiced concerns about the lack of interest and investment on side of agencies as well as responses of disbelief when disclosing abuse, particularly so when the survivor has experienced predominantly psychological abuse. Both survivors and professionals alike regret a lack of effective communication and coordination between agencies such as police and court staff (Grauweiler, 2007).

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In addition to barriers in the process of seeking help, reasons for remaining in abusive relationships continue to be diverse. The feelings of low self-worth for example, are exacerbated by verbal abuse indicating a woman's shortcomings as a parent, which brings doubt about childcare abilities (Parnell, 2007; Woods, 1999). Cultural factors also weigh heavily in the decision making process (Ganley, 1995; Koss & Hoffmann, 2000). Despite the threats to safety within the relationship, leaving a family might be greatly damaging to the survivor when separation is believed to bring shame and guilt not just to the immediate family but also the extended family and parents in law (Koss & Hoffmann, 2000). Cultural expectations and belief systems therefore possibly further complicate a woman's decision to leave while placing responsibility for maintaining a household and family on the survivor. Women from minority ethnic backgrounds are also more reluctant to contact the police or other service agencies for help because of distrust and fear of racist treatment of themselves and their partners (El-Khoury, 2004).

Refuges do not always present a viable choice for survivors. In some areas refuges are not available and realistic fears can accompany a decision to take emergency shelter. Despite the need for safety and well-being, entering emergency housing is often upsetting and can create stress for women and children (Grauweiler, 2007). Entering a refuge involves leaving a familiar lifestyle and environment and contact with family, friends or colleagues to live in a new and often improvised environment under the strict code of conduct of the facility. To some women, entering a refuge also means losing employment and the possibility of finding an affordable lease in her name (Grauweiler, 2007). Many refuges do not allow male children above the age of fourteen into a refuge, leaving women with the difficult decision of whether to leave children with the abuser or

other family members. Most refugees are not able to house larger pets such as cats and dogs but might have arrangements with local pet shelters (WAFE, 2006). Further, emergency shelters are not always prepared to accommodate minority ethnic women and might not be aware of differing needs in toiletries (Sorenson, 1996) or items used for religious practices, and might not have adequate translators or interpreters (Langton, 2007). Despite the awareness of substance or alcohol abuse as consequences of the abuse experience, many refugees exclude individuals with substance abuse issues from service despite the significant numbers of help seeking women suffering from alcohol abuse/dependence (Humphreys et al., 2005). Alternatively, women who flee domestic violence face homelessness, which further impacts negatively on their chances of successfully managing their lives after separation and making re-victimisation more likely. A perpetrator's use of threats and abuse, level of jealousy and his proximity to the survivor are important factors moderating the likelihood for a woman to become the target of aggression again (Bybee & Sullivan, 2005).

In an attempt to understand a survivor's process of leaving, the Stages of Change Model, or the Transtheoretical Model, has been employed by several researchers (Edwards et al, 2006; Burman, 2003; Frasier, 2001). According to this model, women with abusive partners go through six distinct phases in their attempts to resolve the relationship (Frasier et al, 2001). The first stage, pre-contemplation, is a period during which a woman might deny, rationalise or minimise the abuse as a serious problem. During the second stage, contemplation, women are aware of the problems and might acknowledge them to a close friend or family member. She might feel ambivalent and may alternate between caring feelings and questioning of her partner's abusive behaviours. In this stage, women

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often present to the emergency services in an indirect way to seek help and information (Edwards et al., 2006). At the preparation stage however, victims are consciously aware of the abusive situation and are determined to take action, often within the coming weeks. Although this period can be lengthy, the best course of action is decided and preparations are made to carry it out. At the fourth stage, action, women make the change for which they have prepared. Insecurities and concerns are confronted and energy is spent on accomplishing the goal of changing the situation. At the fifth, the maintenance stage, the survivor often struggles with the adversities of this stage (loss of financial stability and status, grieving for positive aspects of the relationship, and dealing with the negative impact of abuse such as depression and symptoms of PTSD). The goal at this time is to prevent relapse. Women may seek support or move to a refuge. As it often takes several attempts before a woman leaves for the final time she may cycle to the contemplation or preparation stage during the last two stages in the process. A final stage, termination, has recently been considered and signifies the complete termination of the relationship and a sense that positive difference has been achieved despite possibly ongoing and long-term struggles with the existence of negative consequences of her experience.

It is important to note here that the use of this model has also sparked controversy. By understanding the behaviour of the woman victim in her process of change, the attention is led away from the actions of the perpetrator (Edwards et al., 2006). Further, women remain with their abusive partners for many complex reasons (including the often warranted fear for her life) and external factors discussed earlier, which might be beyond the scope of a theoretical model. Further, some researchers point out that the process of leaving is non-sequential in

many cases and can vary between the outlined stages, making the stages of change model inappropriate at times (Chang et al., 2006). Despite the objections however, the model has been beneficial in understanding the survivors' difficulties in leaving and in guiding health professionals towards appropriate counselling approaches with survivors.

Although separation can be a lengthy process involving several attempts to leave (Anderson, 2003; Campbell et al., 1998; Goodkind et al., 2003) it is important to note that despite great difficulties, in most cases women do eventually leave their abusive partners (Langhinrichsen-Rohling, 2005; Logan & Walker, 2004). In many cases, active help seeking is precipitated by a critical event, or turning point, which establishes a boundary between acceptable behaviour and abuse (Grauweiler, 2007).

IPV has a significant impact on women's emotional and physical health. The experience of abuse may not only influence an individual's quality of life during the abusive relationship but also for years following separation. Negative self-image, depression and symptoms of PTSD are particularly common problems faced by survivors after abuse. As a result a large number of women with a history of interpersonal violence are users of the mental health system. The negative consequences of abuse such as depression, symptoms of PTSD and negative self-image ultimately impact on treatment (Gleason, 1993) and might hinder women on their route to empowerment and independence. In that way it also informs the choice of intervention and an adequate understanding of the health effects of violence might shed light on the most effective modes/choices of treatment (Romito, 2007). Survivors are likely to seek a variety of resources at different times in their help-seeking process, from family and friends at first to more formal

sources later on. Women deal with a complex variety of issues including problems relating to safety or legal and financial struggles, which are often related to making a comprehensive response to these women's needs useful and necessary (Allen, Bybee & Sullivan, 2004). Taking care of women's basic needs, such as safety and housing, might in turn precede an effective criminal justice response and a woman's willingness and ability to prosecute their partners (Allen, Bybee & Sullivan, 2004) as survivors are more able to concentrate on such legal issues and move toward independence and well-being.

The potential benefits of therapeutic services for survivors should therefore not be ignored. Women who have made the decision to separate from an abusive partner may face a long and arduous journey to heal the negative effects of their experiences (Smith, 2003) and to recover must learn to survive independently, to grief the losses and find meaning in life. While many survivors can deal with these challenges, therapeutic services have been beneficial in assisting women through the phases of recovery. It is vital that those services are supported and their effectiveness maximised. The process of recovery and the possible contribution of therapy after the experience of IPV violence will be the focus of the following section.

1.4. Interventions for Survivors of Intimate Partner Violence

During recent decades, opportunities for victims of intimate partner violence to access safety and outreach services have increased considerably. Multiple services including refuges, crisis hotlines, advocacy, case work services and, in some cases, counselling are now available for women in abusive relationships. Crisis interventions and practical help have become available in

most areas and are important and often life saving services for many women. The long-term negative effects of physical and psychological abuse on survivors however, particularly warrant the need for additional therapeutic services, a need which has not yet been fully embraced (Humphreys & Thiara, 2003). It has been suggested that 50 to 90% of women with a history of interpersonal violence are users of the mental health system (Stenius & Veysey, 2005) but to date, little is known about the effectiveness of mental health services for survivors. The following section will briefly review and discuss the alternatives for women in abusive relationships as well as the effectiveness of those available interventions to date. Therapeutic needs of survivors as well as the effectiveness and efficacy of therapeutic interventions are the main foci of this section.

1.4.1. Survivors' Needs

Women in abusive relationships deal with a complex variety of interrelated issues, making a comprehensive response to these women's needs not only useful, but also necessary (Allen, Bybee & Sullivan, 2004). Because of their complex situations, survivors deal with multiple concerns including safety, practical aid, support, information on financial resources and legal rights as well as therapeutic intervention. A combination of crisis intervention, access to resources and therapeutic services is thought to be beneficial and appropriate for the majority of survivors (Enns, Campbell & Courtois, 1997; Miller, Veltkamp & Kraus, 1997; Sullivan et al., 1992). When seeking safety and information, survivors of IPV are assisted by a variety of institutions. These institutions include the legal system including the police and victim services; social services and other means such as health care professionals or clergy (Moe, 2007). Twenty-four hour

help-lines that offer support, practical advice and referrals to local domestic violence services or solicitors are available in most areas (Krug et al., 2002), however, a large number of victims initially rely on the police or victim services (Moe, 2007) and frequently approach refuges, counselling agencies and mental health services when seeking help. Many women might also disclose the abuse to a friend or trusted family member before any other action is taken (Goodkind, Gillum, Bybee & Sullivan, 2003).

Refuges and safe houses are some of the most widely known options for women in emergencies. These residential facilities allow women and their children (up to a certain age) a safe space and practical help for several months. Women's refuges are a last resort for several thousand women annually and for many a first contact with legal aid and counselling services (WAFE, 2006). The addresses and phone numbers of refuges are confidential and staff members are generally available or on-call 24 hours a day, seven days a week. Not every woman opts to leave her home environment. Legal options for survivors, particularly for women who wish to stay in the home, include injunctions, a court order of protection against her abusive partner, which can result in arrest if it is breached (WAFE, 2006). In the UK, additional safety features in a woman's home are offered such as the implementation of alarm systems, safe rooms and/or secure doors. Further domestic violence services that offer information and support are frequently placed in the community in forms of outreach services, floating support, aftercare, support groups and advocacy services. These agencies can represent a more feasible option for survivors if leaving home is not an alternative, or function as continuing support after exiting a refuge.

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Recovery is often divided into help-seeking, acute crisis, transition and long term reorganisation phases (Broadus, Hermanns & Burks, 2006; Dutton-Douglas, 1992; Walker, 1986). The Stages of Change Model, as previously outlined, has also been helpful in understanding women's needs when leaving an abusive relationship and in developing preventative approaches that guide interventions for survivors in numerous health care related fields (Edwards et al, 2006; Burman, 2003; Hegarty et al., 2008). This model should be used with caution. Women who have experienced IPV should not to be viewed as having the problem-behaviour in need of change, but it is their partners who exhibit the problem behaviour. Survivors are nonetheless faced with a decision making process in their situation to which this Stages of Change model applies (Frasier, Slatt, Kowlowitz & Gowla, 2001). Survivors may seek services at different stages. It is emphasised that each stage requires different interventions or techniques for survivors (Seeley & Plunkett, 2002) and treatment must be appropriate for the stage of recovery (Smith, 2003).

When developing a treatment plan, it is therefore crucial that professionals are cognisant of the woman's stage of recovery when she enters services, which will impact on the choice of intervention (Broadus et al., 2006). During the pre-contemplation and contemplation stages, survivors may benefit most from information about the nature of IPV but with an understanding that she might not yet be ready to make changes. While crisis intervention and practical help might be crucial during acute crises, individual counselling and support groups might be more beneficial during later stages of recovery (Seeley & Plunkett, 2002). Intervention during the action or transitional phase might involve practical help and advice in decision-making and problem solving (Dutton-Douglas, 1992) as

well as motivating personal strengths and survival skills (Burman, 2003).

Survivors seek crisis intervention services such as refuges during acute crises, and in the action stage, but avoid counselling or therapy during and shortly after the crisis, often because they may fear the label of being mentally unstable (Seeley & Plunkett, 2002) and because establishing safety and reduction of harm might be a primary goal at the time of crisis (Dutton-Douglas, 1992; Enns et al., 1997). It is during the maintenance and termination stages, a recovery phase which can last possibly weeks or months after an acute crisis, that a survivor may be ready to deal with the trauma without being overwhelmed, and the healing from the negative psychological effects of abuse can begin (Enns et al., 1997).

Although the establishment of safety and practical help are crucial, survivor-focused therapeutic services are less frequently available during the later stages of recovery. As outlined above, numerous practical services exist to assist women in abusive relationships, however very little data on the benefits or drawbacks of current prevention and intervention efforts is available (Rhatigan, Moore & Street, 2005). A wide range of programmes, including referrals to refuges, are recommended and implemented but have not been sufficiently evaluated to determine their effectiveness in reducing violence and increasing survivors' well-being (MacMillan & Wathen, 2003).

1.4.2. Effectiveness of Practical Interventions for Survivors

Finding safety in refuges, post-refuge advocacy, group work and counselling have been consistently rated as helpful by survivors (Humphreys, Lee, Neylan & Marmar, 2001) and anecdotal evidence from domestic violence workers consistently support the value of their work (Frauenhaus Greiz, 2004; WAFE,

2006). Empirical investigations of services however are sparse. Early studies investigating the effectiveness of services for survivors frequently lack sophistication in methodology and reporting (Abel, 2000) but are nonetheless stepping stones in domestic violence research and have provided important insight into the benefits of interventions for women.

Berk and colleagues (1986) published one of the first studies on the benefits of routine refuge interventions in reducing new violence. Refuge services were found to be helpful in reducing re-victimisation and assisting survivors to take control of their lives (Abel, 2000). However, the authors did not employ standardised measures or specify the services received by the participants. Similarly, Sullivan and colleagues (1992) empirically investigated the effectiveness of a post refuge advocacy programme. The intervention proved not only helpful in assisting women to obtain resources, it was also effective in decreasing fear, anxiety, and depression while increasing feelings of control, social support and perceived quality of life. Unlike Berk and colleagues (1986), the researchers utilised both standardised measures as well as self-made measures in their study (Sullivan et al., 1992). Despite gains in well-being, a large percentage of survivors still experienced abuse after leaving the refuge, even though a substantial number of participants were no longer intimately involved with the perpetrator. This finding supports the notion that the end of a relationship does not always imply the cessation of violence and underscores the importance of safety measures throughout an intervention and beyond. In their follow-up study on the use of advocacy, Bybee and Sullivan (2005) found that three years later the positive effect of advocacy services was no longer significant but women

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who received advocacy services reported continued higher quality of life and less social isolation.

More recently, Bennet Riger, Schewe, Howard & Wasco (2004) investigated the effectiveness of multiple services for survivors of IPV from 54 refuges. The foci of this investigation were crisis hotlines, counselling, advocacy, and emergency shelter. The evaluation tools consisted of adaptations from several standardised measures assessing empowerment, self-esteem and problem solving. Key outcomes differed across all programmes, however, the authors concluded that all intervention services were helpful in gaining important information about violence and in increasing support. Counselling was the only service for which pre- and post-data were available. Consequently, scores on the counselling outcomes scale were significantly greater after the intervention, indicating small but significant changes (Bennet et al., 2004). More specifically, counselling services were helpful in improving decision making ability, self-efficacy, and coping skills. Results should be discussed in light of several limitations. No distinction was made between individual, group or family counselling and the number of counselling sessions per survivor was only slightly more than two. Further, no control groups were used and all self-report measures were constructed by the researcher. The research was carried out by service providers rather than independent researchers and attrition was a substantial barrier to collecting follow up data.

Despite their limitations, the studies by Berk et al. (1986), Sullivan et al. (2004) and Bennett et al. (2004) provide some encouraging insight and have been important in highlighting the importance of services for survivors. These studies also indicate that therapeutic interventions are an important and sought component

after crisis interventions. Unfortunately, the majority of refugees in the UK are not able to implement counselling services specialising in the treatment of survivors of IPV. At this time, the experience and the successful processing of trauma are rarely adequately addressed in many routine interventions for survivors (Stenius & Veysey, 2005). It has been proposed that specialised service, training of counsellors, and standards of practice in therapeutic work with survivors of IPV are necessary in order to minimise harm and maximise positive treatment outcomes (Seeley & Plunkett, 2002). Both researchers and clinicians have hence advocated for survivor-focused therapy for women and believe that therapeutic interventions beyond crisis services are necessary and should be more readily available to address the complex needs of domestic violence survivors (Paul, 2004; Turner & Shapiro, 1986; Walker, 1999).

1.4.3. Therapeutic Needs of Survivors

As outlined previously, the needs of survivors can differ depending on the phase of recovery. It has been acknowledged that therapeutic work cannot begin unless safety is established (Dutton, 1992; Walker, 1981) and domestic violence workers are in agreement that assessment and enhancement of the family's safety is the first and most important factor in any approach with survivors and should remain a primary goal throughout the intervention (Browne 1993; Enns et al., 1997; Housekamp, 1994; Monnier, Briggs, Davis & Ezzell, 2001; Paul, 2004; Seeley & Plunkett, 2002). Traumatic experiences in particular, should not be processed unless this can happen in a safe, supportive and non-judgemental therapeutic atmosphere (Enns et al., 1997; Housekamp, 1994; Paul, 2004; Seeley & Plunkett, 2002).

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Therapeutic needs evolve around working through trauma, changing of negative self-perceptions and alleviating symptoms of depression and PTSD. Empowerment is a further important component in therapy. A therapeutic setting allows survivors to work on the negative self-views including low self-esteem and self-efficacy. This setting also allows for assistance with the expression as well as perception of a wide range of emotions and learning to set boundaries (Holiman & Schilit, 1991). Specific elements that can be beneficial for women in counselling include naming or labelling the violence as such, providing information on the nature of domestic violence, the common responses to abuse and resources for survivors, assisting survivors in identifying their own strengths and placing the blame on the perpetrator (Seeley & Plunkett, 2002).

The processing of trauma has been recognised as a central component of interventions with women survivors (Dutton, 1992; Houskamp, 1994). Several suggestions have been made for the work with symptoms of PTSD, often incorporating the exploration of trauma and reconnecting with society (Seeley & Plunkett, 2002). The work with survivors of IPV is still largely influenced by research and practice developed in the 1990s. More recently, informed by a greater understanding of responses to trauma and developments in neurobiological research, the work with trauma survivors is shifting. Individual responses to traumatic events are given more weight in therapeutic encounters, along with client's differing needs in recovery. Unlike described by trauma therapists as crucial in the 1990s, the re-exposure of traumatic events in a therapeutic atmosphere is thereby not considered a priority, but rather the individual choice and control over the therapeutic work. Instead, resiliency factors, strengths and adaptations to abnormal situations are of primary importance rather than the

pathology of symptoms. Also, differing approaches as well as combining therapeutic elements in working with trauma (such as in somatic approaches, EMDR, etc.) have become more widely acknowledged. These important developments also play a significant role in the trauma work with women today.

In 1992, Dutton-Douglas proposes that the traumatic effects of the relationship can be addressed in a four component intervention including, a) working through the trauma, b) decreasing specific symptom patterns, c) cognitive restructuring and d) rebuilding a new life. Similarly, Enns and colleagues (1997) propose that systematic work through trauma may happen during several phases such as psycho-education, stabilization, ego building, trauma resolution and reintegration. For the purpose of the following discussion, therapeutic phases in trauma treatment outlined previously by professionals are summarised as: 1) psycho-education; 2) addressing the trauma and reactions to trauma; 3) stabilisation/working through negative effects of abuse; and 4) rebuilding and reintegration.

Education about IPV and instinctive reactions to these circumstances can be therapeutic and are now frequently part of crisis intervention and support groups such as the “Freedom Project” implemented in refuges in the UK. Refuges present a first opportunity for many survivors to deal with the reality of her situation within a support system of women in similar situations. Refuges therefore also present a suitable space for the beginning of therapeutic intervention for women (Walker, 1981).

A second significant and necessary part of therapy involves addressing traumatic experiences. Regardless of the theoretical orientation, therapy for survivors should always encourage disclosure of the traumatic events (Broadus,

2006). Being able to recount experiences while being heard and expressing emotions in a safe environment is part of the healing process and a catalyst for positive change and boundary setting (Dutton, 1992; Holiman & Schilit, 1991). Unexpressed anger and powerlessness are common in the work with survivors of IPV (Holiman & Schilit, 1991; Seagull & Seagull, 1991) and women may benefit from learning how to accurately attribute anger and the expression of feelings without fear (Walker, 1981). Houskamp, (1994) proposes that working through the trauma can begin by lessening the emotional numbing and avoidance through naming the violence, which can be achieved by incorporating journaling, imagery or body work into the therapy. In addition, strategies for working through intrusive symptoms could be explored with the use of stress management and relaxation techniques (Houskamp, 1994). Normal and common reactions to traumatic experiences including eating or sleeping problems, anxiety, substance abuse or low self-esteem as well as an impaired sense of self should be addressed and discussed in the context of the abuse, rather than as separate problems. Re-experiencing the traumatic events in the safe and therapeutic environment, managing subsequent stress, facilitating expression of emotion including grief, anger and/or shame, and finding meaning from the experience are important themes in the work through trauma (Dutton, 1992). Mourning the losses survivors had to suffer throughout living with and after leaving an abusive relationship is a further central component of processing traumatic experiences and should have an adequate place in therapy (Dutton, 1992; Monnier, 2001; Smith, 2003; Turner & Shapiro, 1986). These losses can incorporate the loss of personal property, the idea of an ideal marriage/partnership, security, status, family as well as the loss of youth or time. Women should also have the opportunity to mourn the loss of

control of their bodies when they were beaten as part of the integration of negative experiences into the survivors' view of reality (Walker, 1981).

During the reintegration phase of treatment, foci of therapy include empowerment and autonomy (Dutton-Douglas, 1992; Paul, 2004). A process of enabling the client to make her own decisions, rather than taking a position of power and determining decisions or outcomes for her (Seeley & Plunkett, 2002). Empowerment in therapy is promoted by affirming a client's right to her own thoughts, feelings, and needs as well as making her own choices, even if they do not correspond with the therapist's or others' wishes (Dutton, 1992). Disrespect for a survivor's decisions might contribute to feelings of lack of control or disparagement that are hindering the therapeutic progress (Smith, 2003). Strategies for maintaining boundaries and risks for future victimisation could also be addressed during the last phase of treatment (Houskamp, 1994). As a step towards empowerment, Enns and colleagues (1997) believe that it can be helpful to name the meaning of her own experiences. In a respectful and understanding manner the therapist can work on legitimising feelings while reassuring the woman that her responses were, and are, normal reactions to the situation (Seagull & Seagull, 1991). Coping mechanisms, both helpful and counterproductive, should be discussed within the therapeutic setting. Counterproductive mechanisms might include substance abuse, avoidance of emotion, or self-harm (Enns et al., 1997). Although this has given rise to some debate, some clinicians find it can be helpful to work on issues such as substance abuse, that may exacerbate mental health problems and are usually outside of provisions given by refuges (Hien, Cohen, Miele, Litt & Capstick, 2004; Humphreys & Thiara, 2003). Assessing not only formal and informal support networks but also the client's own strengths and

coping capacities can be a foundation for developing new skills during this stage (Enns et al., 1997). Instead of focusing on deficits, positive ways of coping and the ability to find her own way should be stressed (Seagull & Seagull, 1991).

Appropriate and effective treatment is based on the professional's ability to understand and empathise with the survivor's experiences and resulting problems (Holiman & Schilit, 1991). The practitioner should therefore be familiar with the dynamics of IPV, physical and mental health problems following trauma and ways of managing them as well as legal guidelines and practical resources available to the woman and how to access them (Enns et al., 1997; Miller et al., 1997). Similarly, clinicians should be cognizant of the myths and misconceptions about domestic violence and cultural ideas such as the responsibility of the woman for the family (Paul, 2004). Education about negative effects of abuse including symptoms of PTSD can be therapeutic and can validate a survivor's suffering (Dutton, 1992). However, it is helpful to remain aware of inappropriate labelling and diagnoses that might contribute to victim blaming (Enns et al., 1997). Particularly in the work with survivors of IPV it is essential to communicate in an empathic and non-judgemental way and be collaborative and actively supportive of the client and her attempts to regain of personal power. The validation of the experience and the assurance that such behaviour is illegal and inappropriate, comprise a crucial first step in therapy and remains important throughout intervention (Browne, 1993; Paul, 2004).

Survivors report that being able to disclose the violence, being believed and listened to respectfully was an important step in therapy and deemed most helpful by survivors (Seeley & Plunkett, 2002). Lack of training or understanding and poor therapeutic skills are reported to be the most harmful elements (Stenius

& Veysey, 2005). It becomes clear that not only therapeutic skills but also therapeutic relationships play an important role in the work with survivors. Positive, honest relationships between a client and a therapist who provides security and respect are key to women's healing (Seagull & Seagull, 1991; Stenius & Veysey, 2005). Counsellors who provide support, encouragement and specific information about domestic violence are continuously thought to have a positive impact on survivors (Seeley & Plunkett, 2002).

1.4.4. Therapeutic Services for Survivors

Interventions for survivors remain under debate. The focus on therapy, i.e. the mental health problems of women who have experienced IPV, have particularly concerned activists and researchers who focus on domestic violence as a political problem while trying to avoid a medicalisation of violence against women (Humphreys & Thiara, 2003). The diagnosing of survivors in mental health services raises concerns about pathologising and categorising women and therefore missing opportunities for empowerment. Labelling a survivor as having mental health needs is also thought to take the responsibility for the negative effect of abuse away from the abuser (Humphreys & Thiara, 2003). Professionals, particularly those coming from a feminist perspective, believe that not only diagnoses but also assessment instruments as well as therapy for survivors may further pathologise and blame women for the violence they have experienced (Agnew-Davies, 2006; Housekamp, 1994). In addition, the assessment of symptoms, either through clinical interviews or standardised measures, as well as some intervention techniques, such as flooding, can be stressful for women who may feel re-victimised by those procedures (Dutton,

1992; Stenius & Veysey, 2005) particularly when clinicians are inadequately trained in the work with women who have experienced IPV.

Despite the debate, due to the complex nature of the experience and the often chronic negative consequences for survivors, therapeutic interventions might be a necessary and beneficial addition to crisis services and practical help for women. Although well suited to make central contributions, the psychological community still remains on the margins of proactive intervention with survivors of domestic violence (Browne, 1993; Paul, 2004). Therapy can be helpful in assisting women to make sense of and work through traumatic experiences (Seeley & Plunkett, 2002). Recent studies investigating the usefulness of mental health services for survivors of IPV found that women's experiences with these agencies ranged from neutral to negative (Humphreys & Thiara, 2003). Experiences with in-patient services and psychiatrists were often poor and women with complex needs, particularly minority ethnic women, were unlikely to have their needs addressed by mental health services. Humphreys & Thiara (2003) suggested that mental health professionals either ignore the reality of domestic violence or engage in victim-blaming. Due to this lack of involvement, specialised therapeutic services are rarely available for survivors in refuges. Numerous recommendations of potentially beneficial approaches for working with survivors of IPV have been made and treatment plans have been outlined by clinicians and researchers alike (Dutton-Douglas, 1992; Enns et al., 1997; Holiman & Schilit, 1991; Housekamp, 1994; Humphreys & Thiara, 2003; Miller et al., 1997; Monnier et al., 2001; Turner & Shapiro, 1986; Walker, 1981). Despite the apparent agreement over the course, therapeutic process and important elements in therapy for women from abusive relationships, few empirical studies exist that

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investigate the effectiveness of therapy for survivors of IPV (Bennet et al., 2004; Howard et al., 2003) and valuable information about the benefits of interventions with this population is sparse, despite the pressures to provide evidence based practice (Abel, 2000).

The lack of outcome evaluations is attributable to several factors. With the growing pressure from funders to provide evidence based practice, the interest in outcome based treatment has grown only recently. Further, survivors are not a homogenous group and the unique characteristics of survivors' situations warrant services that are flexible and open ended in nature, which complicates the design of efficacy studies for this population. Similarly, withholding treatment to women in crises in order to obtain a control group is unethical (Abel, 2000). Some service agencies might also find funder-enforced evaluations not only intrusive and unhelpful but also responsible for taking valuable time needed for service provision (Bennett et al., 2004). In addition, not all funders who require evaluations provide the resources necessary to undertake such evaluations (Bennett et al., 2004).

Few professional experiences are more demanding than the work with survivors of IPV (Dutton, 1992). Not every client might proceed in therapy through treatment stages outlined by clinicians or in a specified order. Therapy for survivors can also be time limited and exacerbated through weeks of missed therapy sessions (Enns et al., 1997). Survivors of IPV, and particularly those with PTSD and co-morbid substance abuse problems, are considered a difficult to treat population for which poor session-to-session treatment compliance is usual (Hien et al., 2004). Women drop out of treatment because they frequently find themselves in transition and it can be difficult to make therapy a priority (Monnier

et al., 2001). Many survivors in therapy do not seek long term treatment and frequently return to the abusive partner, which can be frustrating for therapists who might not be able to see positive changes or assist women for longer periods of time (Broadus, Hermanns & Burke, 2006).

Establishing a therapeutic relationship might be impeded by survivors' difficulties with trust and intimacy in relationships, including the therapeutic relationship (Enns et al., 1997). Fear of the abuser is in some cases also generalised to fear of all men. This can be a particularly important issue for male therapists. It is therefore often suggested that female therapists are more appropriate. It has been noted that in the work with survivors of IPV the maintenance of appropriate boundaries is important. Physical contact should not be used without permission and the use of self-disclosure should be considered carefully, as using this technique excessively might feel like a violation of boundary rules (Enns et al., 1997). There are no neutral statements for survivors, and actions and behaviours of the therapist either condone or reinforce the violence, a notion of which therapists should be cognizant (Paul, 2004).

The experience of domestic violence is difficult to understand, communicate and accommodate (Miller et al., 1997). During initial phases of therapy, women might not present with the abuse as the problem but with other related symptoms, which could include abdominal pain, headaches or other forms of somatisation, even when they are not directly linked to the abuse by the survivor (Miller et al., 1997). Within a therapeutic environment women might hesitate to discuss their experiences for several reasons. Experiences with violence and abuse might be difficult to put into words and/or to discuss with another person (Enns et al., 1997). Reluctance to talk about the abuse might also be a way

of denying the abuse, minimising shame or fear (Houskamp, 1994), and can be part of a survivor's cognitive distortions, such as justifying the abuse and adopting the abusers skewed world view, or memory problems of which the survivor is not aware (Enns et al., 1997). Disclosure of the abuse may seem to some survivors like a violation of the code of loyalty to a partner to whom they might still feel attached (Enns et al., 1997; Walker, 1981). Fear of retaliation from the abuser if he finds out that the abuse has been discussed can impact on women's decisions to discuss the abuse, particularly if the survivor is still in contact with the perpetrator. The use of services can also be used against the survivor in court cases as an attempt to give evidence for alleged mental instability and to discredit a woman through her use of mental health facilities (Humphreys & Thiara, 2003).

Further, survivors of IPV might be hesitant to use mental health services when a referral to therapy is thought to exacerbate a woman's stigma within her family or community and when the need for outside help can be seen as a weakness that not only brings dishonour to the victim, but also her family. This might be of particular importance for women from minority ethnic communities (Humphreys & Thiara, 2003). Women from some minority ethnic backgrounds may also have fears about contributing to negative stereotypes and stigmatisation of their cultural groups (Hage, 2000), which can contribute to a reluctance to seek therapeutic help or engage with a therapist. A large number of treatment services do not specifically deal with cultural issues, although taking cultural differences in responses to violence and the management of symptoms into account can make a crucial difference in any intervention (Koss & Hoffman, 2000). Creativity, flexibility and training in cultural issues as well as an understanding of culturally relevant decisions regarding the abusive relationship not only aids a better

awareness of the client's situation, it can also prevent ineffective treatment (Dutton, 1992; Koss & Hoffman, 2000).

Because IPV differs from other traumatic events and the work with survivors can be challenging, intervention efforts should be based on extensive knowledge about domestic violence, its prevalence and its effects on physical and mental health (Enns et al., 1997; Hage, 2000; Seeley & Plunkett, 2002). Abuse of intimate partners may involve repeated assaults, isolation, constant fear and abuse that can last several weeks or years. Because some survivors are thought to have co-morbid disorders and substance abuse problems, a tailored approach to therapeutic services might be warranted (Hien et al., 2004). In addition to depression and PTSD, additional problems can complicate treatment for survivors of intimate partner violence (Kubany et al., 2004). As described previously, these problems may include guilt, shame, prolonged and repeated trauma, and in many cases, continued contact with the abuser. At this time, the inconsistency and lack of services currently available for women with mental health needs or substance abuse problems are of concern (Stenius & Veysey, 2005). Because of the complexities involved, survivors of IPV can be a uniquely challenging group for professionals in a helping position. Without appropriate training and understanding, interventions with survivors can be poorly managed (Housekamp, 1994) possibly resulting in more harm, re-victimisation and a continuation of negative effects.

1.4.5. Effectiveness of Therapeutic Services for Survivors

Although there is encouraging evidence of the effectiveness of therapy with other populations, few researchers have turned their attention to the meaning

and benefit of therapy and counselling for survivors IPV. The studies available to date differ widely in their approach, methodology and assessment and the variety of interventions examined further complicate comparisons between studies. The treatment of PTSD and depression has received particular attention from researchers and clinicians. Currently, widely supported treatments for women with PTSD include psychopharmacology and psychological treatments such as Cognitive Behavioural Therapy (CBT). CBT is an approach which has demonstrated efficacy in ameliorating symptoms of PTSD, depression and anxiety in numerous studies (Seedat, Stein & Carey, 2005).

In an early study, Bowker and Maurer (1986) examined the effectiveness of counselling services for survivors offered by various agencies including the clergy, social services or counselling agencies and women's support groups. Women's retrospective reports of their experiences were used to assess the popularity and helpfulness of services (Bowker & Maurer, 1986). The researchers were not only interested in the effectiveness of services as rated by the users but also in the most commonly utilised services. One thousand survivors responded to mailed questionnaires and personal interviews. Bowker and Maurer (1986) reported that social services/counselling services were the most frequently utilised services for survivors at that time. In this sample, frequency of violent incidents, rather than severity, were predictors of service utilisation (Bowker & Maurer, 1986). Participants rated women's groups highest in effectiveness, followed by social services and counselling. Clergy was least likely to be rated as effective by the respondents.

Tutty, Bidgood and Rothery (1993) examined support groups for survivors of IPV. Support groups are frequently a treatment of choice and are more readily

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offered within refuges and community service agencies. According to the researchers, women's support groups generally have common goals and focus mainly on the woman's safety, the recognition of violence, reduction of self-blame, enhancement of self-esteem, and an understanding of why abuse occurs. In addition, support groups can assist in developing social networks and provide opportunities to vent anger and frustration (Tutty, Bidgood & Rothery, 1993). The researchers compared 12 similar support groups, which were offered for 10 to 12 weeks to 89 participants within refuges. Ten standardised measures were used to assess constructs including self-esteem, coping, locus of control and stress in this investigation. Sixty women completed the groups and were available to provide post intervention information. Thirty two women participated in a follow up assessment six months later. The study provided insight into the benefits of support groups, which are thought to increase self-esteem and coping ability while reducing stress. Participants indicated a shift from external to internal locus of control. The groups also seemed to have a positive impact on the participants' current relationships and reduced physical and non-physical abuse for survivors who remained with the perpetrator, albeit complete cessation of abuse has been recorded for only one participant. These gains were maintained several months later. Numerous factors might have impacted on the outcomes of this study however. Over half of the participants still resided with their abusive partner during the course of the study, possibly impacting on the course and outcomes of the group. Further, the study did not utilise a control group or differential treatment conditions, making a judgement of the client gains due to the groups impossible. Attrition further constituted a problem and the small number of

women in the follow up group seemed to be those who have benefited most from the intervention (Tutty et al., 1993).

Howard and colleagues (2003) investigated counselling outcomes for 500 physically and sexually abused survivors. Levels of self-blame, self-efficacy and control, as well as social support were assessed via an author-constructed questionnaire and used to measure effectiveness of individual and group counselling sessions. The participants were divided into two groups (1) physically abused and (2) physically and sexually abused women. According to the researchers, all participants made equally significant gains in wellbeing over the course of counselling, an encouraging result supporting previous studies showing benefits of interventions for survivors of IPV (Howard et al., 2003). No control group or standardised measures were used and no differentiation was made between the type of intervention participants received (i.e. individual versus group therapy) or the theoretical approach of the intervention.

The studies reviewed above investigated general therapeutic interventions offered in refuges, however, no theoretical approach or framework has been specified. The failure to differentiate between therapeutic approaches can be problematic. Not only researchers, but also funders request an indication of which approach is used with success in practice. There are few studies available that investigate individual approaches used with survivors of IPV or sexual violence.

1.4.5.1. Cognitive-behavioural Approaches

Much of research on the effectiveness of therapy for survivors of different types of trauma has focussed on interventions with cognitive and behavioural components or techniques (Bryant, Havery, Dang, Sackville & Basten, 1998; Dutton, 1992; Enns et al., 1997, Foa, Olasov, Rothbaum, Riggs & Murdock, 1991;

Hien et al., 2004). Psychotherapies under the umbrella term of Cognitive-behavioural Therapy (CBT) aim to challenge and change thoughts, emotions and behaviors that relate to a dysfunctional appraisal of events. It is believed that CBT can be beneficial in reaching treatment goals for survivors such as changing faulty patterns of thinking through re-education, and developing more self-enhancing ways of thinking, feeling, and behaving (Webb, 1992). CBT techniques designed to assist survivors communicate their experience, such as exposure, or forms of CBT like Cognitive Processing Therapy (CPT) designed to teach individuals to recognise and challenge dysfunctional cognitions about their traumatic events, have been reported to be effective in reducing symptoms of PTSD (Stapleton, Taylor & Asmundson, 2007; Resick et al., 2008). Hence, CBT is frequently used with survivors of sexual violence and includes several techniques that encourage exposure to the events (Broaddus et al., 2006).

Detailed instructions for group approaches from a cognitive-behavioural framework specifically for survivors of domestic violence with PTSD have been outlined by numerous clinicians and researchers. Monnier and colleagues (2001) recommend spending therapy time on educating survivors about domestic violence (including myths and stereotypes), allowing grieving for the losses, validating women's feelings, exploring childhood trauma, addressing old patterns of thinking and cognitive distortions, recounting experiences and memories of the trauma/abuse, but also focussing on pleasurable activities and empowerment.

Maynard (1993) investigated the effectiveness of 12 cognitive-behavioural group treatments in reducing depression, anxiety, hopelessness and self-esteem in women. The study employed two experimental conditions, one structured cognitive-behavioural group and one unstructured support group that encouraged

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catharsis and understanding among participants; and an untreated control group. The researchers found significant changes on all measures in the cognitive-behavioural group but not in the support group or the control group. Hien and colleagues (2004) investigated 24 sessions of two types of individual cognitive behavioural treatment designed for women with PTSD and substance abuse problems. It was found that both cognitive behavioural interventions were superior in reducing substance use and symptoms of PTSD to community care which entailed outpatient psychological treatment, medication, or self-help meetings for substance abuse problems. These results are helpful in light of the relationship of substance abuse and the experience of trauma.

One of the earliest studies on the effectiveness of an intervention for survivors with cognitive behavioural as well as psycho-educational components was conducted by Cox and Stoltenberg in 1991, who were interested in investigating changes in mental health difficulties as well as vocational benefits. Two experimental groups, differing only in the administration of an additional personality questionnaire, and one control group were employed in this study. Standardised instruments were chosen to assess changes in self-esteem, locus of control, anxiety and hostility, assertiveness, depression, and 'career maturity', a measure to assess career counselling needs. Participants in the experimental group received 6 sessions of therapy within two weeks whereas women in the control group received unstructured group counselling weekly. Twenty two of initially 50 participants completed the study, representing an attrition rate of over 50%. No significant change on any of the measures was reported for any participant in the control group and both experimental groups differed from each other in most outcome measures. Significant differences pre- to post-test on the measure of self-

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esteem have been noted in both experimental groups, but not in the control group. However, these mixed outcomes should be evaluated in light of the limitations such as attrition and the difference in length of interventions between control and experimental groups.

Similarly, Holiman and Schilit (1991) investigated the effectiveness of a 10 week psycho-educational group intervention that employed cognitive and expressive exercises. Levels of anger, self-esteem and general contentment of the 12 participants were assessed through standardised instruments before and after the intervention. The Physical Abuse Scale and the Verbal Abuse Scale served as screening instruments. The goal of the intervention was to help survivors focus on themselves and although no significant changes in self-esteem were reported, the authors discussed positive changes in anger and general contentment. The group was thought to be a positive experience as reported by participants at a follow up session (Abel, 2000). However, the study was limited by the small number of participants and the lack of a control group.

More recently, Kubany and colleagues (2004) investigated a cognitive behavioural approach, which particularly considered the issues brought to treatment by survivors of IPV with PTSD. In the intervention named Cognitive Trauma Therapy for Battered Women (CTT-BW), techniques such as education about PTSD, stress management and exposure were used to challenge negative self-talk and guilt-related beliefs. One hundred and twenty five survivors participated in this study and completed a large battery of standardised tests, which addressed the spectrum of traumatic events, symptoms of PTSD, depression, self-esteem, guilt, and personal feelings before and after participating in 8 to 11 individual treatment sessions. Client satisfaction with the intervention

was additionally assessed. Participants were randomly assigned to immediate or delayed treatment conditions. Eighty percent of participants completed the programme, those who dropped out were more likely to be younger, less educated, more depressed, and had lower self-esteem at the initial assessment. The authors report significant changes in the pre- and post-treatment scores of all measures in the experimental group. Symptoms did not significantly change for participants in the delayed therapy condition between the two pre-therapy assessments, however after completion of therapy 87% no longer met PTSD diagnostic criteria.

1.4.5.2. Feminist-oriented Approaches

In recent years, mental health professionals have turned their attention to the effects of violence on women and thereby changed domestic violence from a solely political issue to one incorporating psychological issues as well (Seeley & Plunkett, 2002). Because many practical interventions with survivors are based within a feminist framework, individual and group counselling from the feminist perspective is consistently recommended in treatment. It is believed to be an approach least likely to produce secondary victimisation of victims/survivors as it places sole responsibility of the violence on the perpetrator (Seeley & Plunkett, 2002). The feminist viewpoint suggests that the existence of domestic violence, and particularly the violence by men towards women, highlights the less valued status of women in society (Seeley & Plunkett, 2002). The awareness of such is part of therapy. The foci in Feminist Therapy are on learning that violence against women is a global societal issue, rather than an individual problem, as well as symptoms of guilt and shame (Broaddus et al. 2006). From the feminist perspective, violence in intimate relationshipd happens because of society

sanctioning the misuse of power by men over women (Housekamp, 1994). Enns and colleagues (1997) advocate for therapeutic approaches based on a feminist orientation that take into account the various influences on a survivor, such as the impact of trauma, trauma history, developmental factors, family influences and the cultural context in which IPV happens (Enns, Campbell & Courtois, 1997).

The effectiveness of therapeutic interventions from a feminist framework has rarely been empirically studied. In an early study, Rubin (1991) investigated outcomes of a group intervention from a feminist perspective with 12 participants, of whom six completed the study. In this exploratory study, two outcome measures were constructed to assess women's current feelings, thoughts and behaviours. Outcomes were recorded via daily phone interviews. The degree of further abuse was also assessed as the majority of participants still lived with or returned to their partners at the time of the study. Due to the small sample size and the lack of a control group, the inconsistent number of group sessions attended by the participants (attendance ranged from one to six sessions during the intervention phase), and attrition rates, the researcher concluded that the data provided do not give sufficient support for the effectiveness of the intervention (Rubin, 1991). The fact that the women in the study either lived with their abusive partners or returned to them during the course of the study might have had an important impact on the outcomes of the study.

Mancoske and colleagues (1994) investigated the effectiveness of feminist-oriented counselling and grief resolution counselling for survivors. Twenty participants completed standardised measures assessing self-esteem, self-efficacy and attitudes towards feminism before and after the intervention. Goals of the feminist-oriented intervention included improved self-esteem, confidence,

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assertiveness and awareness of conditions that lead to abuse of power within relationships. Grief resolution drew from the idea that grieving for the loss of the relationship is a key component in healing. The intervention included Kuebler-Ross's (1969) five stages of mourning as well as management and reduction of denial, anger, isolation and depression. All participants received crisis intervention in addition to either group (the feminist counselling group or the grief resolution group), which consisted of short-term counselling lasting eight weeks. All women who took part in either intervention tended to improve somewhat on self-esteem, self-efficacy and 'attitudes toward feminism'. Participants in the grief resolution group however improved significantly on the measures of self-esteem and self-efficacy whereas despite the positive trend, improvements for the feminist oriented group remained not significant. The results suggest that a focus on grieving in therapy with survivors can be beneficial in improving self-esteem and self-efficacy. However, the small sample size and the lack of a control group should be considered when interpreting the results.

The two studies reviewed do not support the benefits of feminist-oriented counselling suggested in other papers (Sharma, 2001). Although much of the political work with survivors and activism is built on a feminist perspective, this approach might not be as beneficial in psychological therapy. It has been suggested that in order to honour the diversity which exists amongst women, feminist counselling should become more understanding and knowledgeable about culture and the significance of race, ethnicity, and sexual orientation (Sharma, 2001).

1.4.5.3. Family Systems and Conjoint Approaches

One of the approaches suggested for reducing violence within families has been family and couple therapy from a family systems perspective. This approach has also received significant criticism. It has been believed that ignoring the differential power structure within abusive relationships might place the woman at a higher risk of abuse after she discusses the violence in therapy, particularly in the presence of the perpetrator (Housekamp, 1994). The embedded assumption of equal power is further thought to contribute to blaming the victim for the violence (Tutty et al., 1993). Many clinicians believe that effective therapy for women who have experienced violence is based on a safe, supportive and non-judgemental relationship in which the survivor's perceptions and feelings are validated (Housekamp, 1994; Murray, 2006), these assumptions might not be guaranteed in conjoint treatment.

Notwithstanding the criticism, family interventions and conjoint therapy are suggested to be valuable in many cases of family violence (Murray, 2006). According to Schlee, Heyman and O'Leary (1998) conjoint treatment is desired and sought by many couples in abusive relationships. A family therapy approach can focus on the elimination of the abuse while improving the relationship. In their study with 38 couples who completed a conjoint therapy programme, Schlee and colleagues examined the effectiveness of conjoint treatment for women with and without PTSD. Standardised measures were used assessing symptoms of PTSD, depression, the level of violence experienced, women's fear of their husband and adjustment. Women with PTSD were no more likely to drop out of treatment than women who were not diagnosed with PTSD. However, a greater amount of avoidance symptoms was associated with drop out of treatment (Schlee

et al, 1998). In general, participants reported less fear of their husbands after treatment, and the results indicate significant improvements on all measures for women. However, no control group was used in this study and the presence of the perpetrator might have had an unmeasured influence on treatment.

O’Leary, Heyman and Neidig (1999) compared the effectiveness of gender specific and conjoint treatment approaches for reducing physical and psychological aggression in couples in abusive relationships. Thirty-seven couples completed treatment and standardised assessments were used in a pre- and post-test with a follow up design. All therapists followed a detailed manual. The researchers report a significant reduction in aggression and marital improvement across all groups and suggest that neither treatment type outperformed the other. Notwithstanding, despite reductions in frequency and severity, physical and psychological abuse was still present at follow up. It is important to note that couples in this study agreed to participate in therapy in order to reduce aggressive behaviour and to improve their relationship. Neither study supported fears that conjoint treatment compromises the victim’s safety.

1.4.5.4. Person-Centred (Humanistic) Approaches

Until recently, the Person-Centred approach as developed by Carl Rogers (1951) has received little attention in the trauma literature. However, some clinicians believe that this approach can be as beneficial, or more so, than contemporary treatments in reducing the negative effects of trauma, and assist personal growth after abuse (Joseph, 2004). Unlike technique-based approaches such as CBT, Person-Centred Therapy (PCT) is based on the therapist’s ability to create a positive social/therapeutic environment that enables the client to change. It is believed that an individual’s innate tendency towards self-actualisation and

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integration/wholeness will be supported through the provision of six conditions in therapy outlined by Rogers (1951). These six necessary and sufficient conditions for change involve two persons in psychological contact, one (the client) is in a state of incongruence, the second (the therapist) is integrated and congruent in the relationship, the therapist experiences unconditional positive regard for the client, as well as an empathic understanding of the client's frame of reference, the therapist is able to communicate the unconditional positive regard and empathic understanding (Rogers, 1992). PCT has been used successfully with a wide variety of populations including women with low self-esteem and alcohol abuse problems, many of whom also experienced IPV (Lillie, 2002). The potential of PCT for survivors of trauma has been recognised more recently by Payne, Liebling-Kalifani and Joseph (2007) who promote PCT as a way to encourage healing after a traumatic event. The non-directive, client-centred approach is frequently used in therapy with victims of sexual assault (Robertson, 1990) in the work with survivors of IPV (Langton, 2007 personal conversation; Woman's Trust, 2006 personal conversation). It is thought of as one of the few approaches that promotes a sense of control for survivors and puts women "back into the driving seat of their own lives" (Robertson, 1990, p. 47). Because of the basic belief that the person knows what is best for them and will follow this path if the right conditions are given (Lillie, 2002) PCT is believed to be empowering and appropriate for survivors of intimate partner violence. Payne and colleagues (2007) assessed the effectiveness of PCT in a pilot study. Six participants, including one survivor of IPV, participated in this exploratory investigation and received between 5 and 15 sessions of PCT. Psychological growth following trauma, current psychopathology, symptoms of PTSD, perceived levels of positive

regard and empathy were assessed utilising standardised measures. The study indicated mixed results for the effectiveness of the group, however, all but one participant reported reduction of problems and symptoms after the intervention. In particular, half of the participants reported reduced symptoms of PTSD. For the survivor of domestic violence the PCT approach was effective.

Participants of this study varied widely in their opinions of whether the group provided the core conditions of PCT as outlined by Rogers (1951). As a result, Payne and colleagues (2007) conclude that the quality of the therapeutic relationship is a crucial part in the evaluation of PCT and the nature of the therapist-client relationship should be explored in PCT research. Client-centred therapy is not necessarily what the therapist says it is but what the client perceives it to be. A further obstacle in PCT research is the administration of questionnaires – an idea that counters the crux of facilitating therapy from the person-centred perspective. Because of its great potential in the work with survivors of domestic violence and despite the challenges presented to researcher in this area, PCT should be evaluated in more detail in future studies (Joseph, 2004; Payne, Liebling-Kalifani & Joseph, 2007).

1.4.5.5. Unique therapeutic Approaches

In addition to traditional approaches several innovative approaches have been advocated for use with survivors. Because women in abusive relationships are frequently isolated and might be limited in their pursuit of career goals and skill development, Chronister & McWhirter (2006) suggest that vocational guidance can be beneficial in helping women remain outside of abusive relationships. Chronister and McWhirter (2006) investigated the effectiveness of two career interventions, which differed only in strategies for enhancing

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awareness of the impact of IPV violence on survivors' career development. The researchers found that career interventions significantly increase career related self-efficacy. However, since the focus of the research was on career related goals it is not clear how effective career interventions are for reducing the negative sequelae of abuse.

Reed and Enright (2006) suggest an innovative intervention which focuses on survivors' unique challenges to recovery. Seagull and Seagull (1991) believe that survivors have a barrier to reaching treatment goals, termed 'accusatory suffering', which maintains resentment and victim status because healing is believed to excuse the perpetrator's negative behaviour. 'Forgiveness therapy' has been developed by Reed and Enright (2006) to promote the reclamation of valued personal qualities, without neglecting the injustice of the abuse. In a study investigating the effectiveness of Forgiveness Therapy, 20 survivors were randomly assigned to the treatment group or the control group for a minimum of five and a maximum of 12 months. Standardised tests assessing forgiveness, self-esteem, anxiety, depression, environmental mastery and meaning making were completed by participants before and after the intervention. In comparison with the control group, women receiving Forgiveness Therapy showed a significant increase in environmental mastery, meaning making (i.e. finding meaning), and reductions in depression and symptoms of PTSD. Although this research investigated an innovative approach to therapy with survivors, the study had several limitations. Only a small number of participants received either therapeutic intervention, no treatment protocol was used and the research was carried out by the investigator who also devised the approach.

Similarly, a particular programme of cognitive therapy with an underlying feminist structure was evaluated by Zust (2006). The 'INSIGHT' programme is a general intervention for women and designed to be empowering, to nurture a woman's self-awareness and understanding, and to reframe negative messages that impact on self perception. According to Zust, a woman's positive sense of self is key factor in ending and recovering from an abusive relationship. Interventions that foster the woman's self-discovery and acceptance are needed (Zust, 2006). In this qualitative study the meaning of participation in the 12 to 20 weekly sessions for 10 survivors of IPV is assessed. Numerous examples of positive changes in participants were reported. Meanings associated with group attendance were comprised of several aspects related to rescuing the self. Metaphors used are 'grabbing a life jacket', 'becoming buoyant', and 'finding ones land legs'. These phases are reflective of stages of recovery previously discussed in section 1.4.1.

1.4.6. Art Therapy Approaches

Of particular interest in the current study are creative arts approaches as treatment modalities for survivors of IPV. Within therapy, expressive techniques such as drawing, painting, drama and journaling can provide a useful tool for exploring and expressing intense feelings. These techniques might provide an opportunity to self-reflect (Enns et al., 1997) but also to explore new possibilities and directions. Particularly writing and creative arts have been suggested to play a beneficial role in encouraging the process of stopping the depersonalisation and dissociation between body and mind (Walker, 1981) and in processing the abusive relationships. Writing about stressful events has been associated with decreases of

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depression and anxiety for a variety of populations including rape and sexual abuse survivors, and it is consequently believed to promote the cognitive processing of abusive events for survivors (Koopman et al., 2005). Studies on the effects of expressive writing with survivors of IPV suggest that although results were not statistically significant, writing about trauma may reduce symptoms of depression when levels of depression are high at baseline. Follow-up studies did not replicate these findings, partly due to small numbers of participants and additional attritions rates of 22% (Holmes et al., 2007).

Although often seen as non-traditional, innovative creative arts approaches have much to offer in the area of domestic violence. A particular method – Art Therapy – has already been suggested numerous times for the work with women and children who have experienced domestic violence. According to The British Association of Art Therapists, Art Therapy is a form of psychotherapy that uses art media as its primary mode of communication. The aim of this form of therapy is to enable a client to effect change and growth on a personal level through the use of art materials (BAAT, 2008). At this time, Art Therapy is frequently used in clinical practice with children in refuges who have experienced violence from and between parents (Bass-Feld, 1994; Ferrell, 2006, personal conversation; Walters, 2005). Art Therapy is also used frequently with physically and sexually abused women in prisons (Merriam, 1998), for children and adults with low-self esteem (Franklin, 1992; Kramer Borchers, 1985) and with numerous individuals in various mental health settings including individuals suffering from panic disorder and agoraphobia (Albertini, 2001); schizophrenia and trauma (Laub & Podell, 1995; Odell-Miller, Hughes & Westacott, 2006). Because of the positive results in the work with a variety of populations, Art Therapy has been chosen as the

subject of interest in the current study. The approach, its definition, use and function as well as its purpose in this study will be discussed in more detail below.

1.4.6.1. Art as Therapy

Art Therapy is a non-verbal discipline, which provides another language for expression of thoughts and feelings. This form of psychotherapeutic intervention has evolved from a large focus on psychoanalysis. Despite its longstanding roots, Art Therapy as a profession enjoyed a relatively recent development (Case & Dalley, 1992; Edwards, 2004, Kaplan, 2000). Although the training of Art Therapists in the UK is still influenced by the profession's psychoanalytic roots, but more contemporary movements include more flexible and eclectic approaches. Many art therapy professionals now adapt the approach to fit the needs of clients in different settings and few would take a solely psychoanalytic perspective, Hogan's criticisms (1997) notwithstanding. Art Therapy, much like counselling, developments have made it a complex and continuously evolving profession. Increasingly art therapy practitioners around the world, particularly in the US, (but also in the UK) work with different theoretical orientations (Rubin, 2001). Increasingly their theoretical orientations are adapted in response to client need and available evidence.

Particularly relevant for the current study is Liesl Silverstone's approach to Art Therapy. In her therapy, Silverstone draws largely from the theories of Carl Rogers' Person-centred therapy. To her, interpretation of client's art work is perceived as hindering the personal development while person-centredness, in Art Therapy as much as in its original form, aims to empower individuals (Silverstone, 1996).

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Art therapy has developed in two different strands. On one hand, art psychotherapy, (where art was used in therapy), was developed through the pioneering influence of Margaret Naumburg in the 1940s. This psychoanalytically oriented Art Therapist focused on the release of unconscious material through spontaneous art expression. To her, art was a way to state feelings the client does not understand. Naumburg asserts that the advantages of using art material in a therapeutic setting include a) the permission of the expression of inner experiences in the form of images rather than words, b) that these images escape censorship more easily than verbal expressions, which may in turn speed up the therapeutic process, c) durable and unchanging images, whose content cannot be forgotten (Ulman, 2001). On the other hand, Art Therapy, (art making as therapy) evolved through perspectives of artists like Adrian Hill or Edith Kramer in the 1950s, who believed in the function of Art Therapy in assisting with sublimation (Bass-Feld, 1994). Kramer proclaims that the act of art-making offers an opportunity to re-experience, resolve and integrate conflict (Ulman, 2001). The first strand stresses the importance of the therapeutic relationship between the client, his or her art work, and the therapist. The latter emphasises the healing properties of art. Therapeutic change can be due to the therapeutic relationship or to the creative process itself. Many art therapists now argue that therapeutic change happens due to a synthesis of the two and hence it involves both the process of art making, the product (or finished image), and the provision of a therapeutic relationship (Edwards, 2004).

For most individuals language and words are the main means of communication. The philosophy of Art Therapy however, builds on the premise that human experience cannot be entirely reduced to words and that some

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emotional states are beyond words. (Edwards, 2004). It has often been asserted that art making is inherently therapeutic and by using this mode of communication, Art Therapy offers something that cannot be provided by other disciplines (Kaplan, 2000). It enables individuals to effect personal change and growth using art materials (Odell-Miller et al., 2006) and images are used to understand and communicate events, associations and feelings. Art Therapy allows clients to gain a better understanding of him or herself and the nature of their distress and offers the possibility for a positive and enduring change of the client's sense of self (Edwards, 2004). The therapist plays an important role in helping clients to understand this process as well as the product. Art and art making can also be a means to support and foster the therapeutic alliance. The client can relate to the therapist through the art object, which can be the focus of discussion, a record of the therapeutic process, and serves for reflection in future sessions (Case & Dalley, 1992). The creative process is used to facilitate catharsis, reconcile emotional conflicts, increase insight and encourages change and growth (Bass-Feld, 1994).

1.4.6.2. The Process of Art Therapy

Art therapy uses creative media to help clients express their thoughts, feelings and experiences (Saunders & Saunders, 2000) and involves the use of different media through which an individual (the client) can express him/herself and work through issues which brought them to therapy (Case & Dalley, 1992). Creating art and art as communication has been an activity since ancient times. Each piece of art "has its own significance as well as that of the time, place and original reason for its creation" (Case & Dalley, 1992, p. 50).

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When looking at the more contemporary application of Art Therapy, it can be defined as a form of therapy in which the creation of images and/or objects is central to the therapeutic relationship. Images and image formation as well as the physiology of emotion are important areas of Art Therapy. “Images have a significant impact on our bodies” and can be “a bridge between body and mind” (Malchiodi, 2002, p.18). The images created in Art Therapy are of central importance as they invite participants to reframe their feelings, respond to their traumatic experiences and work on both emotional and subsequent behavioural changes. As Malchiodi (2002) points out that “art making allows an individual to actively try out, experiment with, or rehearse a desired change [...] that is, it involves a tangible object that can be physically altered” (p.19).

Art and Art Therapy are different activities (Burleigh & Beutler, 1997). Artistic activities – that is the recreational use of art material, can also be used in treatment of mentally ill individuals. Art Therapy is not, as often mistaken, an art class. Large differences exist between Art Therapy and art education. It also differs from other types of art making for recreational and even therapeutic purposes. Art education – which stresses technique or instruction but is not aimed at assisting favourable changes in personality or behaviour nor is it concerned with individual needs. (Ulman, 2001). The difference between Art Therapy and art education is that “Art Therapy has evolved from rehabilitation, diagnostic healing, and symbolic speech towards and expansion of consciousness (Stokrocki, Sutton Andrews, & Saemundsdottir, 2004) p. 81).

As an intervention, Art Therapy is thought to offer the means of expressing unconscious as well as conscious emotions, thoughts, sensations, fantasies, conflicts and experiences through the creation of images that serve as symbolic

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equivalents (Cooper & Milton, 2003). Many, particularly psychoanalytically trained Art Therapists, believe that art is able to bridge the inner world with the outer reality through the use of images as mediators (Care & Dalley, 1994). Most importantly, the creative process can help to understand and process losses and other traumatic or painful experiences (Cooper & Milton, 2003). Art Therapy is often offered within a group setting. As a basic difference between group Art Therapy and group verbal therapy, each group member works at his or her art separated from the group for the majority of the time, which shapes the group dynamic. This can include the 'performance fear' and insecurity felt about working with a new medium, but on a more positive note art can offer alternative or additional methods of expression, past incidents can be re-enacted and shared with the group, art objects can contain symbolic meaning important for therapy, art work can be manipulated - even at a later date, and can be the focus for interaction, and Art Therapy is less threatening than a verbal group for many people. Lastly, creative activity can be challenging and rewarding for participants (Waller, 1993). In addition, working on art within a group can have a significant social function. The intervention can be offered as in a variety of ways – the studio-based open group (where the art process is seen as curative and the Art Therapist takes on a non-directive role), the analytic group (direct influence from verbal group therapy, usually a closed group, non-directive about the art work but working with unconscious themes), and the theme centred group (group process to find a group theme from free floating discussion, emphasis on social factors). The therapeutic process will become established within the safe space which is created by the art therapist. As in any therapeutic relationship, a contractual arrangement is made between the art therapist and the client based on patterns of expectations.

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The therapeutic conditions act as a therapeutic container and the safe space in which feelings and thoughts are allowed to emerge. Boundaries include a set and agreed starting and finish time (Case & Dalley, 1992) as well as group rules.

1.4.6.3. The Use of Art Therapy

Art and Art Therapy have immense benefits to offer (Kaplan, 2000).

Participating in art activities can be deeply satisfying and gratifying for healthy as well as ill individuals. For persons using art therapeutically, externalizing inner visions can help to improve and extend them to other real life situations. Working within a group can solidify interpersonal bonds that further promote health in modern society. In the work with children, art making and art play encourages mind-brain development, which is important for perceptual discrimination, language acquisition and self-esteem. Visual art expression facilitates problem solving and other forms of creativity and is therefore useful in organising thoughts (Kaplan, 2000)

Several recent studies have demonstrated how art making helps to reduce chronic pain (Camic, 1999), and supports individual's ability to cope with stress or symptoms of illness (Anand & Anand, 1999, Gabriels, 1999; Hildebrand, 1999, Lusebrink, 1990). Art Therapy reduced a variety of symptoms in cancer patients such as pain, fatigue and anxiety (Monti et al., 2006; Nainis et al., 2006). Art Therapy is often used in the treatment of persons suffering from schizophrenia. Some of the most often mentioned goals and achievements of Art Therapy with a variety of populations are self-expression, improvement of self-esteem (Green, Wehling, Talsky, 1987), coping, and self control, gaining of insight as well as the improvement of social competencies (Brooke, 1995; Green et al., 1987; Filip, 1994; Burleigh & Beutler, 1997; Smeijsters & Cleven, 2006).

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Recently, Art Therapy is considered a mind-body intervention, meaning this therapeutic approach can influence the mind's capacity to influence bodily symptoms (Malchiodi, 2002). Art expression has therefore been considered particularly important for individuals recovering from trauma, which is said to not only take a toll on the mind but also the body. An approach that not only focuses on managing negative experiences but also involves all senses, including touch and smell, can be helpful in activating the expression of sensory memories and connected emotions and hence the processing of traumatic events. Art Therapy is often the more accepted choice of intervention by consumers and is "the treatment of choice in many situations where short-term, goal-oriented therapy is indicated" (Riley, 1987, p. 21).

Malchiodi (2002) further points out that Art Therapy can be used to "tap the body's relaxation response" (p.21). Art making provides participants with opportunities to self-soothe and self-heal. Observation and anecdotal evidence, particularly with children, suggests that the creation of art has a soothing and relaxing influence on individuals who are anxious or suffer from post-traumatic stress.

1.4.6.4. Art Therapy and Survivors of IPV

Art-making can be used in assessment, diagnosis and treatment. One of the most deciding factors for the choice of Art Therapy as intervention in the current study is the influence of Art Therapy on sufferers of trauma. Many survivors of IPV have experienced terrible and humiliating situations, for which they might not easily find words. As mentioned above, some emotional states are beyond words (Edwards, 2004), but the management of the effects of such experiences is a major part in the recovery from domestic violence. Art Therapy can play a very

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crucial role for women in refuges and although little empirical evidence exists for its usefulness with this population, many professionals are convinced of the power of art for survivors. For example the creation of art has been mentioned as a functional way for homeless survivors of domestic violence to heal, protect and support them (Stokrocki et al., 2004). Art making was also mentioned as a functional way to express feelings and to satisfy women's needs by doing art for themselves rather than for someone else (Stokrocki et al., 2004). In many institutions, including refuges or domestic violence shelters, Art Therapy is becoming an important part of treatment and agencies working with survivors are using this method increasingly (Palmquist, 2003). For women recovering from intimate partner violence, art offers a way of healing and empowerment and provides an important avenue for self-discovery. The effectiveness of Art therapy has been investigated empirically previously with survivors of sexual abuse by Brooke (1995). In her study, 6 women in the experimental group received weekly group Art Therapy sessions for two months. A waiting-list control group of 10 participants received no intervention but provided scores for a standardised self-esteem measure. Self-esteem was measured with a standardised instrument before and after the intervention. Scores increased significantly in the experimental group and only marginally for the control group lending support to the hypothesis that Art Therapy is effective in improving self-esteem. The use of Art Therapy for survivors of IPV in refuges has been recommended in 1987 by Lagorio, who investigated the effects of Art Therapy as a treatment tool for survivors in a qualitative study. Art therapy sessions were given weekly within refuges for the duration of 9 months. According to Lagorio, prominent themes of therapy sessions included denial of anger and the minimisation of abuse in the future. The

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sessions were thought to be greatly beneficial in improving self-esteem in survivors. Lagorio supported her results with descriptions of several case studies. Following her investigation, the author believes that Art Therapy can be an effective educational tool as well as a vehicle for finding insight, identifying feelings, learning about and appreciating self and improving communication skills. Although Art Therapy and art making has been suggested by others as a useful method for survivors recovering from the negative effects of abuse (Stockrocki et al., 2004), no other empirical studies investigating its effectiveness or efficacy for survivors have been conducted. Despite the lack of empirical investigation of creative approaches, particularly Art Therapy, the use of this approach with other, similar populations shows immense potential for its application in the work with survivors of domestic violence. Art Therapy is therefore worthy of further investigation.

Although not extensive, the existing research is encouraging and adds evidence to the assumption that therapy and counselling can aid significantly in the successful recovery of women who have experienced abuse. The reviewed studies differ greatly on numerous variables such as type and place of intervention offered, length of intervention, design, and research methodology; making a comparison between them difficult. However, it seems that in particular Cognitive Behaviour Therapy (Kubany et al., 2004), Art Therapy (Brooke, 1995; Lagorio, 1989) and Person-Centred approaches (Joseph, 2004; Payne et al., 2007) can be effective in improving self-esteem and decreasing symptoms of depression and PTSD for survivors. Studies to date have several limitations. They further rarely utilise standardised instruments in their assessment of psychopathology or treatment gains. Even when the same constructs such as self-esteem or PTSD are

measured, the assessment tools differ widely. Frequently, the lack of a control group and non-randomised assignment to treatment conditions makes it difficult to attribute positive gains solely to the intervention. Most importantly, in almost all studies attrition created a barrier to collecting outcome or follow-up data (Bennett et al., 2004; Cox & Stoltenberg, 1991; O'Leary et al., 1999; Rubin, 1991). The work with survivors of IPV violence is regarded as challenging for numerous reasons and particularly difficult to evaluate.

Despite these challenges, therapeutic interventions for survivors of IPV are necessary and can be immensely beneficial for women recovering from abuse. From the review of the literature it becomes clear that a positive collaboration of all agencies involved and accessible community based services are crucial. A professional relationship between counsellors, outreach workers and/or refuge staff can be greatly beneficial in increasing the safety of families and allowing the survivor to build a new, independent life. To maximise this collaboration numerous professionals, clinicians and researchers alike, advocate for a greater focus on efficacy research and investigations of the effectiveness of therapeutic interventions for survivors. There is still much to be learned about the efficacy of interventions for survivors of IPV and further studies are necessary to extend the cumulative evidence base and add to existing knowledge of what works for women in need of intervention.

2. RATIONALE, PURPOSE AND HYPOTHESES

2.1. Rationale

It is clear that abuse between intimate partners is a problem that cannot be ignored and should not be minimised. As previously outlined, abuse not only affects women at all socio-economic levels, regardless of age, religion or ethnic background, it also significantly contributes to a nation's financial burden. Most importantly, IPV has far-reaching acute and long-term physical and mental health consequences for those who experience it and hence contributes considerably to disability-adjusted life years (Prince et al., 2007). With one in four women in Europe experiencing domestic violence in their life time, interventions that reduce further abuse and improve the health and well-being of women should be at the forefront of research and practice. However, there is still uncertainty among professionals, particularly those in health care agencies, about which interventions are the most appropriate for survivors of IPV (Ramsay, Rivas & Feder, 2005). The evaluation and discovery of appropriate and effective treatment models is considered the most important area for future research (Hage, 2000; Smith Stover, 2005).

Psychological treatments for survivors can be greatly beneficial. Few psychological interventions have been sufficiently researched and are infrequently financially supported as funders press for evidence of their effectiveness. The few available funds are more likely spent on validated interventions, leaving other possibly beneficial approaches unrecognised or undervalued. The aim of the current study is to add to the existing knowledge about effective treatments designed to lessen the negative mental health effects of women who have experienced IPV. The foundation of this investigation is formed by two

(overlapping) needs in the areas of counselling and domestic violence – the need for evidence-based practice (the validation of therapeutic approaches) and the need to explore interventions that are particularly useful for survivors of IPV.

2.1.1. The Need for Evidence-based Practice

Much of today's work in health care and related fields is based on the idea that care is improved when empirically validated approaches are used. The basic premise of evidence-based practice is that practitioners should know the available evidence concerning a therapeutic approach and its likely outcome when intervening in the lives of other individuals (Goss & Rose, 2002). Despite this important concept, the need for evidence based practice, or the restriction of practice to validated approaches, can be problematic for practitioners. Access to current research outcomes can be limited for clinicians in the field. Furthermore, validated approaches might differ from professional beliefs and/or individual training. Although it is agreed that there is much to be learned about effective and efficacious approaches in therapeutic work, many practitioners are reluctant to engage in research because of time constraints, limited funding, or the difficulties of combining and using empirical inquiry with the introspective skill of therapy (McNiff, 1998; Payne, 1993). Most importantly, it can be challenging to standardise many psychological interventions for research since in reality and outside a strict research setting, practitioners often adopt an integrative approach rather than a single 'pure' type of therapy. The gold standard of psychotherapy research is represented by randomised controlled trials (RCTs) - the comparison of participants who have been randomly assigned to treatment or control groups in a tightly controlled experimental setting. It can however be problematic to

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conform RCTs to a theoretical ideal that represents the every day experience of practitioners (Goss & Rose, 2002). Explicit inclusion and exclusion criteria in research settings also do not always apply to real life in many cases. Findings of current psychotherapy outcome research have hence been considered limited because they may not generalise to the way therapy is conducted in real life. Although cognitive-behavioural therapy (CBT) has been empirically evaluated and is recommended for managing the symptoms survivors of IPV face (such as depression and PTSD), in the practical work with women survivors many different approaches are employed. These include Feminist Therapy, psycho-educational approaches, Person-Centred Therapy (PCT) and other innovative approaches such as Art Therapy. Despite the overwhelming evidence and support of the use of cognitive-behavioural approaches, PCT is the model of choice for many agencies working with victims of sexual and physical abuse in practice (Robertson, 1990; Langton, 2007, Women's Trust, 2008). Similarly, Art Therapy has been used successfully with numerous victims of trauma (including sexual assault) and with women and children survivors of IPV (Brooks, 1995; Malchiodi, 1997; Walters, 2005). More recently, Art Therapy has been a valued therapeutic approach in domestic violence refuges throughout the United States (Palmquist, 2003; H.E.R. Shelter, 2008). Unfortunately, such real-life approaches have rarely been under investigation and therefore infrequently seen as viable options in the work with abuse survivors. The gap between research and practice and the associated problems have also contributed to the split between practitioners and researchers that has led to frustration on both sides. It is vital that not only clinical practice but also innovation and development are not obliterated by a very strict adherence to clinical guidelines and policies (Goss & Rose, 2002; Goldfriend &

Wolfe, 1998) since intervention, and therefore research into the effectiveness of interventions for survivors, are crucial in consideration of the immense chronic and lethal health consequences of IPV (Zink & Putnam, 2005).

2.1.2. The Need for Research in the Area of Domestic Violence

As discussed previously, the negative effect of abuse from an intimate partner does not necessarily cease with the end of abuse. Campbell and colleagues (1995) found that although depression ceases over time for survivors of IPV, a large number of women were still at least mildly depressed six months after exiting a refuge. Forty three percent of participants who had left a refuge were re-assaulted after six months. Of those women 71% percent were at least mildly depressed at follow up. Of the women who were not re-victimised, 60% were still at least mildly depressed. These results suggest that even after leaving a refuge, a large number of survivors still battle the negative mental health effects of abuse and are at a risk for future abuse. Therapeutic interventions can play a significant role not only in alleviating the symptoms associated with IPV but also in empowering and assisting women to live positive lives that are free from future abuse. Humphreys and Thiara (2003) postulate that rates of mental health difficulties, and in particular depression, are highest among women in refuges. Campbell and colleagues (1995) also suggest that survivors who feel a loss of control over their lives report greater rates of depression. A perceived loss of control can be exacerbated by the necessity to hide from an abuser in a refuge while being isolated from family and friends. A primary goal of therapeutic intervention is to re-establish the feelings of control in women's lives and to empower individuals to live a life free from abuse. Empowerment is therefore a

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significant aspect in therapy with survivors and refugees and/or community outreach centres, which represent an appropriate place to begin services that not only tackle the lack of support and tangible resources but also increase women's psychological well-being.

A significant number of services are offered to residents and participants by refugees and community outreach centres, which include crisis intervention, house meetings and one-on-one conversations. However, additional therapy is rarely available. Preliminary investigation revealed that counselling is often sought and wanted by women in refugees. Although not all women may need therapeutic intervention, other than being removed from harm, many individuals may find therapy helpful in their healing process. In a study evaluating the benefit of community services for abused women, Gordon (1996) showed that refugees as well as survivor-focused counselling agencies ranked highest in helpfulness for women in crises, and many women are likely to turn to these agencies for help. In a study on the healing processes for survivors, women reported availability and institutional responsiveness (such as availability of crisis services), trauma-specific treatment, female therapists and women only groups, empathy and shared experience most helpful (Stenius, 2005). Women make an average of six attempts to leave their abusive partners (Burman, 2003; Mruga, Helfrich, & Finlayson, 2004), effective interventions to support the independence and empowerment of women are therefore crucial. It is therefore essential to support the positive impact these services have. Paul (2004) believes that, unfortunately "the psychological community rarely involves itself in proactive intervention with women abused by partners" (p. 8) and particularly the field of counselling psychology should be much more actively involved in changing violence against women (Hage, 2000).

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Smith Stover (2005) believes that research on the effectiveness of current treatment models is not promising. Little quantitative research is available on specific interventions for survivors (Seeley & Plunkett, 2002). Methodological weaknesses in studies investigating effectiveness of interventions have been criticized by numerous researchers (Ramsay et al., 2005; Abel, 2000). Such weaknesses include inconsistent randomization, lack of controls, lack of blinding, no follow-up or only short term follow up and inadequate outcome measures (Zink & Putnam, 2005). Although it is clear that research in the field needs to be advanced, it is not always clear how this should happen. Zink and Putnam (2005) suggest that more qualitative, descriptive and mixed method studies are required in domestic violence intervention research. The authors further suggest that a collaboration between researchers, practitioners and community partners such as refuges and/or outreach centres is crucial in furthering the understanding of effective approaches with survivors. The current study aims to take these suggestions into account.

The idea of therapy for survivors of IPV has been under debate during the past decades (Agnew-Davis, 2006) and there are strong opinions about the usefulness and necessity of available therapeutic services. Therapists agree that therapeutic intervention (especially early intervention) can significantly reduce the impact of abuse on the lives of women (Paul, 2004) while activist and professionals in the field believe that treating the individual woman labels already marginalised women and takes attention away from the true social issues. Despite the debate, it has been felt by professionals and researchers alike that health care professionals have a unique and crucial opportunity to assist survivors of IPV (McCaw et al., 2007; Golding et al., 2007). Some even believe that a survivor is

no longer a victim when she begins counselling. Because this crime differs from other traumatic events however, intervention efforts should be survivor-focused, i.e. based on extensive knowledge about domestic violence, its prevalence and the outcomes of such experiences for survivors (Hage, 2000) so that the therapeutic environment becomes a supportive setting without possibly harming survivors further.

Many professionals have advocated the utilisation of therapeutic approaches, and particularly group therapeutic approaches, for survivors of IPV (Broadus, 2006; Dutton, 1992; Smith, 2003). Group treatment might be particularly warranted because it counteracts the isolation many survivors feel and can be powerful and beneficial in decreasing shame and loneliness while providing opportunities for social support and for practicing coping and interpersonal skills (Enns et al., 1997; Holman & Schilit, 1991; Housekamp, 1994; Monnier et al., 2001). It has been proposed that therapy in a peer group can further lead to significant changes in anger expression and modify fear responses (Holman & Schilit, 1991). Social support has been outlined as one of the most significant factors in the recovery from abuse and is a mediator for further mental health problems for women in abusive relationships. Levendosky and colleagues (2004) also suggest that support for women having experienced violent relationships plays a key role in the mental health of survivors. Higher numbers of supporters are associated with less depression, higher quality of life, and reduced risk of re-abuse (Bybee and Sullivan, 2005) and increased self-esteem (Levendosky et al., 2004). For women in transitional stages, such as during a refuge stay, positive support (emotional and/or practical) has been associated with greater well-being (Levendosky et al., 2004), and group therapy can be helpful in

providing opportunities to give and receive emotional support. Women who seek help from refuges might already have limited resources and low quantity and quality of social support, which only reinforces the need for therapeutic services within refuges.

It is clear that the need for prevention and intervention is an important one and this warrants consideration of alternative approaches and concepts in the field (Ehrensaft, 2007). As discussed in the previous chapter, there have been few outcome studies focused on the efficacy and effectiveness of therapy in refuges and none specifically on the use of Art Therapy with this particular population. This lack of empirical research has been criticized by several authors in the recent decades (Burgleigh & Beutler, 1997; McNiff, 1998; Payne, 1993) and it is problematic that little empirical evidence exists for creative arts therapies despite their widespread use in clinical settings. Without the grounding in empirical research, the potential of Art Therapy will continue to be unnoticed (Burleigh & Beutler, 1997). Research in psychotherapy and Art Therapy research in particular often consists of case studies and results of qualitative approaches such as interviews and client observation. Although these approaches are extremely helpful and often ground breaking, therapists still find themselves in the position of having to substantiate the success of their approaches. It is therefore key to find appropriate measurement tools and effective methodology to demonstrate conclusive evidence for the usefulness and benefits of Art Therapy (Burleigh & Beutler, 1997).

2.2. Aims and Objectives of the Study

The aim of the current study was to evaluate the effectiveness of therapeutic interventions with adult survivors of IPV in a real life setting. Results

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of the study are intended to contribute to the knowledge base of appropriate and effective treatment models for survivors of domestic violence. The study is based on the wish to add validation to approaches that are already used in clinical practice with survivors and to extend the therapeutic repertoire for clinicians working with women. The particular focus of this investigation rests on two interventions proposed as helpful in the work with survivors, namely Art Therapy and Person-Centred Therapy. Of particular interest are the quantitative assessments of changes in participants' psychological well-being including levels of self esteem, depression and symptoms of PTSD, as well as individual and personal accounts of the therapeutic experience from participants. These aspects have been chosen as those are the most frequently mentioned and serious mental health symptoms women survivors report after abuse. The purpose of these reports is an exploration of benefits, concerns and future directions of therapy from the perspective of the participants. Results of this implementation are qualitatively and quantitatively analyzed and evaluated in order to establish whether or not the application of Art Therapy in comparison to Person-Centred Therapy is efficacious for this population and how these approaches may enhance therapeutic work in this setting.

Group therapy from both approaches will be implemented in British refuges and outreach centres in addition to usual care consisting of crisis intervention, one-on-one meetings with refuge staff, practical aid, access to information and house meetings offered routinely by the facilities. Because of the significant benefits of therapeutic groups, a group approach has been chosen over individual intervention for the purpose of this investigation. The researcher is aware however that individual therapy might be more appropriate than group

intervention for women who feel a great deal of shame about their victimization (Koss & Hoffman, 2000)

Despite empirical evidence for the effectiveness of CBT for depression and PTSD, Person-Centred and Art Therapy approaches have been chosen as foci for this investigation for several reasons. Although CBT strategies have been proven to be effective in ameliorating specific symptoms of PTSD and depression (Seedat, Stein & Carey, 2005), survivors are frequently in complex situations, which warrant the use of a unique or different approach which does more than alleviate their symptoms. Unique approaches to therapy in combination with routine care provided by domestic violence services have been chosen. As empowerment is a significant aspect of psychological treatment and in line with the feminist perspective underlying much of the work in refuges, the nature of both PCT and Art Therapy seem to offer greater opportunities for the empowerment of clients. It is still not clear what role these approaches might play in benefiting survivors and at this time we are still far away from knowing what helps women who have experienced violence manage the negative mental health effects of their experiences. Person-Centred Therapy and Art Therapy are two therapeutic perspectives that can play an important role in therapeutic involvement in the future.

2.2.1. Person-Centred Therapy

According to Joseph (2004) the crux of Person-Centred Therapy is not only a deep understanding of the client's world from the client's perspective but also an acceptance of the client's life directions. This acceptance and understanding is also emphasised by professionals in the work with survivors of IPV. In that way the Person-Centred approach represents a natural choice for

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survivor-focused therapy. Person-Centred Therapy can offer a therapeutic environment, based on an unconditionally accepting relationship in which change is possible (Joseph, 2004). This accepting and non-judgemental therapeutic environment is a basis for successful interventions with survivors. Therapy from this perspective not only focuses on alleviating distress but also on promoting growth (Joseph, 2004), a further important factor in the work with women after abuse. As mentioned previously, empowerment is an important part of counselling survivors of IPV. It is the process of enabling the client to make decisions useful to the individual woman, rather than taking a position of power and determining decisions or outcomes for her. Empowerment in therapy is promoted by affirming a client's right to her own thoughts, feelings, and needs as well as making her own choices (Seeley & Plunkett, 2002). Clients in Person-Centred counselling, including survivors of IPV, are considered experts in their own lives (Seeley & Plunkett, 2002) and in this therapeutic approach are actively encouraged to form a future appropriate to them.

Person-Centred Therapy further offers a conceptual framework for understanding and working with PTSD. The reaction to deeply upsetting events, such as negative intrusive thoughts and avoidance, are considered normal processes that happen alongside attempts to integrate the experiences within a person's self structure and identity (Joseph, 2004; Payne et al., 2007). In line with suggestions from the feminist perspective, women's reactions to negative events are not categorical but lie on a continuum of levels of distress. Joseph (2004) further suggests the sufferers of trauma are often reluctant to engage in therapy or drop out early due to their tendency for avoidance and the fear that therapy could be upsetting. Attrition is a considerable problem in therapeutic treatment of

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survivors and women might be more likely to choose a therapy which is not exposure-based, like cognitive behavioural approaches, but focuses on the client's own speed and direction. The three aspects outlined - the strength-based approach, considerations of normal responses to traumatic events, and a less overwhelming method for working through trauma – make Person-Centred Therapy an ideal therapeutic approach in the work with survivors.

2.2.2. Art Therapy

Art Therapy has been chosen for similar reasons. All Art Therapists have the goal of using art as a tool for providing the client with means to strengthen the ego, providing cathartic experiences, showing the client alternative ways to uncover anger, offering means to reduce guilt, helping the client learn impulse control, and teaching the client to use art as a outlet for emotions (Corsini, 2001). These aspects are also important goals in therapy with survivors of IPV. The expression and understanding of feelings related to traumatic experiences is a significant part of the Art Therapy process. Art-making alone is part of the healing process (Corsini, 2001; Kramer, 2002) and allows the individual to express emotions in a non-threatening way. What makes art as media so useful is its inherent ability to summon emotional, rather than intellectual, responses (Hanes, 2000). Art is also a helpful tool for individuals to put complex experiences, such as trauma, into words and to find control over them (Cohen, Barnes & Rankins, 1995).

As detailed in section 1.4.6., creative approaches have been highly effective for various populations in many areas of the mental health profession due to their accessibility and ability to bridge gaps between clients and therapists (Burick & McKelvey, 2004; Carlson, 1997). The use of creative media can speed

up the establishment of rapport between the client and the therapist and contributes to the creation of a positive therapeutic atmosphere (Carlson, 1997). The literature reveals that Art Therapy has a valuable approach in a variety of settings and has been particularly useful in working through traumatic experiences and increasing self-esteem and self-efficacy. Art is further a teaching tool for the development of cognitive skills (Burick & McKelvey, 2004; Malchiodi, 2003; Rubin, 2001). Because of these benefits, several authors have recommended the use of Art Therapy in the work with survivors of IPV (Lagorio, 1989; Palmquist, 2003) and despite a lack in outcome studies, the approach with abused women has enjoyed increasing popularity in practice.

2.3. Purpose of the current Study

In an effort to shed light on the effectiveness of two under-researched approaches with adult survivors of IPV this study examines the effect of Art Therapy and Person-Centred Therapy. The purpose of this study is to explore changes in well-being after both interventions in comparison to routine care. In the first phase of the study, quantitative research questions will address changes in psychological well-being of women in refuges and outreach centres. In the second phase, qualitative interviews will be used to explore additional, individual aspects of the therapy experience.

2.4. Research Questions and Research Hypotheses

The main questions addressed in the first phase of this investigation are: Does group Art Therapy facilitate an increase in psychological well being, self-esteem and self efficacy while reducing symptoms of PTSD and depression for female adult survivors of IPV? Does group Art Therapy generate similar results to group therapy from the Person-centred perspective? Do women who receive either

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therapeutic intervention improve in psychological well-being in comparison to women in a control condition who receive standard intervention in refuges?

It is hypothesized that both therapeutic groups will improve in psychological well-being in comparison to the control group. In addition, it is believed that the use of art will significantly contribute to an increase in positive treatment outcomes, such as the increase in psychological well-being, that may contribute to the reduction of re-victimization in the future. Changes in depressive symptoms or symptoms associated with PTSD, levels of self-esteem and self-efficacy, use of effective coping skills, and an improvement of overall psychological functioning will be quantitatively assessed. Questions addressed in the second phase of the investigation concern participant's experiences in therapy with the goal of gaining a better understanding of women's expectations of the therapy groups, the results for them personally, as well as the particular aspects that contributed to change or lack of change. Individual reports from participants are hoped to contribute to the understanding of therapy effectiveness rather than verify a pre-existing theory or hypothesis. A better understanding of possible effects of therapy can be of benefit to funding bodies as well as professionals involved in helping survivors of IPV. Too little is known about what works for women who have experienced abuse. It is the researchers ambition to advocate for therapeutic services that are effective, empowering and beneficial for women, and therefore for funding of these. In addition, the current research is an attempt to reduce the existing gap between research and practice. Results of this study are not only geared to inform future research in the field but are first and foremost shaped to inform practitioners who work with survivors.

CHAPTER 3 METHODOLOGY

Considerable thought has been given to an appropriate methodology and to the process of inquiry. It was important to select methods which would be rigorous in the investigation of psychological changes yet flexible to also capture personal nuances of change. The goal was still a representative study with ecological validity (i.e. real-life application). In order to fully capture the effects of the intervention, the investigation was approached from two perspectives. The design includes a quantitative exploration of any changes in well-being after the implementation of the therapeutic intervention as well as the reports from participants on subjective experiences of possible change. The investigation was a quasi-experimental, non-randomised controlled study. Two main methods of inquiry were chosen and used sequentially to complement each other, quantitative research based on questionnaire data and qualitative research in the form of interview data. The focus of this study is not only on measurable changes in participants well-being but also takes into account the individual reports of what are personally seen as significant changes in thoughts or behaviours. A real-life setting and research methods appropriate for that setting have been chosen in order to ensure clinical validity yet generalisability. In addition, the current design enabled working clinicians/therapists to take an important role in designing and implementing the intervention.

The methods used to conduct this exploratory study and to produce outcomes will be outlined in detail in the following chapter. Practical and philosophical perspectives influencing the choice of methodology will also be discussed.

3.1. Issues in Intervention Research

The demonstration of effectiveness of interventions created to improve the well-being of individuals has become of key importance in the field of health psychology. Similarly, the validation of effective approaches has become an equally important element in the work of psychotherapists. In psychotherapy two research perspectives typically inform research interests - the theoretical approach investigating the mechanisms of change and the pragmatic approach, exploring the effectiveness of treatment (Omer & Dar, 1992). Whereas theoretical interests are frequently explored within the laboratory, pragmatic interests are said to be most effectively investigated in a real world setting. However, much of today's psychotherapy research investigating the effects of an intervention or therapeutic approach aspires to clinical RCTs. As a result, the efficacy of an intervention is based solely on empirical results from studies which employ randomised selection of participants to groups, the existence of a control group and strictly controlled experimental conditions. Some researchers believe that although an efficacy study might be able to determine with some accuracy whether a treatment works under experimental conditions, it might not be the best way to determine what actually works in the field (Seligman, 1995). A different focus, one on effectiveness rather than efficacy, can yield more useful results and credible validations of a psychotherapeutic approach. This approach to psychotherapy research investigates how participants fare under actual conditions of treatment in the field (Seligman, 1995). Efficacy studies are designed to detect statistically significant changes but it remains unclear whether statistical difference also equals clinical difference. Similarly, it is not known whether an absence of statistical significance also means an absence of effect? In a therapeutic context, small changes such as

acquired insight on a particular problem, or minute changes in behaviour such as posture or facial expressions, might be considered significant by therapists. These types of changes will not be detected through quantitative analyses.

The current study is a study of effectiveness rather than efficacy for several reasons. As outlined above, because efficacy studies are trials conducted under ideal experimental conditions, this approach is not practical in work with survivors in transition. Research in the area of domestic violence faces several challenges. Because of the unpredictability of IPV, it is often difficult to conduct randomised controlled studies with survivors. As mentioned in previous sections, women disclose violence and enter an intervention depending on a complex interplay of factors including their readiness for change and availability of formal and informal support. Assigning a woman to a treatment group that might not be appropriate for the stage of change she is in, is not likely to yield fruitful results. Similarly, there are difficulties of establishing a no-treatment control for women whose lives may depend on an intervention. Because of the potential danger women and children are in, it is not ethical to assign women to a no treatment control group (Zink & Putnam, 2005). In addition women utilising the services of refuges and/or outreach centres often have complex needs. Strict inclusion and exclusion criteria for therapy groups on the basis of one diagnosis (such as PTSD or depression) while disregarding multiple other problems were not realistic. For these reasons the use of RCTs in the area of domestic violence has been perceived by some scholars as not feasible and unethical (Ramsay, Rivas & Feder, 2005).

When exploring the effectiveness of an intervention for survivors researchers face multiple other problems that might impact not only the choice of approach and methods but also the quality of the outcome. Blinding of

investigators to the status and treatment condition of the participant for example may be difficult. The survivor status and related safety issues are an integral part of the research as well as her care (Zink & Putnam, 2005). In addition, confidentiality of the individual's identity and past experiences are a crucial concern with survivors and can create difficulties in experimental research if blinding is used. Particular attention should be paid to keeping the number of individuals knowledgeable about personal information to a minimum. Conducting follow-up investigations can also be challenging for a number of reasons. Survivors can be potentially transient in order to ensure their safety (Zink & Putman, 2005). Further, women may have been recruited through refuges where survivors may only stay for short periods of time. After leaving a refuge, women may live with friends or again with the abusive partner. In this case they are difficult to contact because receiving phone messages or letters concerning domestic violence can be a source of danger if the abuser finds out that she has disclosed the abuse. As a result, longitudinal follow-up of participants in an adequate sample size is labour and cost intensive. Although randomised controlled trials are the preferred method for intervention research, it is not a realistic gold standard for research in the area of IPV (Zink & Putnam, 2005). Researchers have to be creative beyond the structure of RCTs to conduct useful research and with appropriate methodologies within these constraints. However, knowing what works for survivors is needed sooner rather than later (Zink & Putnam, 2005). There has also been intense debate about appropriate research methods in Art Therapy, despite the common thought that research and evidence for the positive effect of this intervention are needed (Aldridge, 2003). However, art and science overlap on their mutual reliance on creativity. Although some art

therapists have argued that qualitative methods are best fitting to Art Therapy research rather than quantitative, in the current position it is believed that both methodologies are needed in Art Therapy research (Kaplan, 2000).

3.2. Mixed Method Research

3.2.1. The Use of Quantitative and Qualitative Methods

Mixed method research is an approach that involves both forms of research in the collection and analysis of data in a single study, rather than choosing one paradigm and the associated quantitative or qualitative strategies. The use of multiple methods within one study is said to have originated in the 1950s and has only recently received more attention from researchers in the area of psychology (Creswell, 2003). The combining of methods belonging to two separate paradigms is now one of the fastest growing areas in research methodology (Bergman, 2008) but despite its growth this marriage is not without problems. Difficulties in designing effective mixed method studies frequently stem from fundamental philosophical and methodological differences between quantitative and qualitative paradigms. A paradigm is a belief system or set of interrelated assumptions about the social world, which provides the conceptual framework for a study and guides the approach and methods used (Ponterotto, 2005; Tashakkori & Teddlie, 1998) Qualitative research has been associated with interpretive or constructivist positions whereas quantitative research has its roots in positivist (scientific) paradigms (Bergman, 2008; Yardley & Bishop, 2008), two philosophical perspectives which have often been deemed incompatible. It has been suggested that the positivist paradigm could only be combined with

quantitative methods whereas the constructivist paradigm could only be combined with qualitative methods (Hanson et al., 2005).

Quantitative research as an approach to seeking knowledge can be traced back to the beginning of the industrial era and philosophers like Descartes, who believed that the world can only be understood and knowledge can only be gained by accurate observation of manipulations in a controlled environment that lead to precise measurements (Yardley & Bishop, 2008). These methods have been very successful in understanding physical sciences and have been applied to psychology in order to better understand the thoughts and behaviours of individuals (Yardley & Bishop, 2008). Quantitative methods are based on statistical testing and because of the use of precise standardised and reliable measures, quantitative methods have high levels of internal validity that allow researchers to draw causal inferences with relative certainty (Yardley & Bishop, 2008). Quantitative methods are used appropriately for deductive hypothesis testing. However, increases in internal validity often come at the cost of decreases in external validity (Yardley & Bishop, 2008). The qualitative paradigm and associated research methods grew out of an increasing criticism of the objective, scientific method to study human behaviour (Yardley & Bishop, 2008). From this perspective, knowledge and understanding of a phenomenon is mediated by an individual's particular subjective and socio-cultural experiences (Yardley & Bishop, 2008). As it is impossible to set these assumptions and values aside, researchers are never able to achieve purely objective knowledge. The focus of research should not be on discovering cause-effect relationships but on studying normative concepts and practices that shape perceptions of a certain phenomenon (Yardley & Bishop, 2008). The differences between the two paradigms also

concerns basic concepts including causal inferences and the nature of reality. Traditionally, methods used in psychology such as post-positivist approaches emphasize objectivity and non-biased collection and analysis of data (Madill, Jordan & Shirley, 2000). Constructivists on the other hand challenge the idea that there can be absolute foundations for knowledge and that language can represent reality (Madhill et al., 2000). From a constructivist viewpoint meaning must be uncovered through deep reflection (Ponterotto, 2005). Qualitative methods are well suited to gain an understanding of personal experiences and perceptions and although this approach is inappropriate for deductive hypothesis testing, it is an ideal method for inductive hypothesis generation. On the other hand, because data and the interpretation of data are done in context, precision and control over external variables is sacrificed (Yardley & Bishop, 2008). Controlled experiments employed in quantitative research do not take into account the participant's individuality and the social context, which gives meaning to behaviour. Objectivity however gives the scientist a ground to stand on and upon which knowledge claims can be based (Yardley & Bishop, 2008).

Qualitative methods have been the foundation for early theory and practice in counselling and psychotherapy but were the less likely method of choice in recent decades due to the bias towards quantification in academic research and pressures for quantitative evidence from funding agencies. In many areas of psychology, including psychotherapy outcome research, the emphasis on documenting behaviour and quantifying outcome assessments has favoured quantitative research paradigms (Ponterotto et al., 2008) and only recently, researchers and professionals have called for a re-examination of current research methods that may hinder the exploration of new therapeutic approaches and stifle

developments of the field of counselling psychology (Ponterotto, 2005). Critics of purely quantitative approaches, particularly those in the field of counselling psychology, believe that the narrow focus on positivist and post-positivist paradigms has dominated the field of counselling psychology and psychotherapy research and contributed to the lack of advancement in the field (Ponterotto, 2005). At this time, qualitative research is more diverse than ever before (Brown & Locke, 2008). More recent approaches embracing qualitative and quantitative methods are thought to contribute to new developments and insights about therapeutic approaches.

For the past decades, purists in each tradition have believed that a combination of both approaches is impossible and methods are incompatible (Hanson et al., 2005; Tashakkori & Teddlie, 1998). Despite much research on pragmatic approaches to mixing methods as a way of countering paradigm-method links, some debates still exist (Hanson et al, 2005). Nonetheless, researchers endorsing the use of more than one paradigm believe that the differences between methods have been overdrawn and that the schism between paradigms is not as deep as been made to believe (Tashakkori & Teddlie, 1998). There is as much diversity within the paradigms as there is between them and often qualitative methods can be used in a quantitative way. Realist interview-based description of participants' beliefs and experiences with therapy has more in common with a survey of their beliefs rather than other qualitative methods investigating socio-political functions of language for example. Similarly, quantitative methods, such as the collection of questionnaire data, can be used with an awareness of the influence of the assumptions and constraints of the research method on the findings, a perspective akin to the constructivist approach.

Further, quantitative data and the sometimes surprising findings must be interpreted much like individual accounts of experiences. In this way, interpretation of findings contribute to the amendment and/or development of theory (Yardley & Bishop, 2008).

Despite the schism between quantitative and qualitative research, philosophical differences have been overcome successfully in numerous applied studies. Researchers embracing mixed method research frequently use both qualitative and quantitative methods because these approaches can complement each other and provide a balance across strengths and weakness (Yardley & Bishop, 2008). The use of both methods can enrich findings more than a single approach alone would be able to do. By combining both forms of data, researchers may be able to simultaneously generalize results from a sample to a population but also gain a deeper understanding of the phenomenon they are investigating (Hanson et al, 2005). While fundamental differences are upheld in theory, they are often blurred in practice (Bergman, 2008). Although the differences in theoretical perspectives can be and have been overcome, many researchers stress the importance of awareness to these differences so that assumptions of each approach are not violated when mixing them. Because the scientific method is dominant in the field of psychology, it is often adapted by default and an unawareness may consequently lead to the use of inappropriate criteria to validate research methods (such as large random sample, reliability testing, etc.) in qualitative research (Yardley & Bishop, 2008).

In the current study, relevant strengths of quantitative methods include the use of standardised measures and procedures which help to maximise internal validity and reliability of measures. Most importantly, the questionnaire method

makes a systematic comparison between intervention groups possible and allows for the control of extraneous variables. Advantages of qualitative methods in the current study involve the ability to gain in-depth knowledge of participants' experiences with the intervention as well as their opinion of its effectiveness. The use of interviews allows for the inclusion of a range of views from individuals who are considered experts of their own lives and represent a population for whom the study is most relevant. Experimental data (questionnaire data) is used in a deductive way (to illustrate a theory) whereas interview data is used inductively because the outcome of the interviews was not clearly known prior to analysis.

3.2.2. The Philosophical Basis for combining Methods

The philosophical rationale for combining qualitative and quantitative methods in the current study was informed by a pragmatic approach to research. This theory can be and has been a framework for deconstructing the stereotypical differences between paradigms and combining research approaches successfully (Yardley & Bishop, 2008; Tashakkori & Teddlie, 1998). Pragmatism has been advocated as an alternative paradigm situated between qualitative and quantitative research (Ponterotto et al., 2008) and has been proposed by scholars such as John Dewey as an approach to counter the paradigm-method link (Tashakkori & Teddlie, 1998). It has been suggested by numerous researchers as an appropriate framework to link qualitative and quantitative methods (Hanson et al., 2005; Johnson & Onwuegbuzie, 2004). This philosophical basis has been chosen over composite analysis, in which both types are done as part of one study but evaluated separately (Tashakkori & Teddlie, 1998) or the dialectical perspective,

from which both methods are utilised equally with an acknowledgement and in honour of the different features from each (Hanson et al., 2005).

As a way to counter the paradigm war, pragmatists consider truth to be ‘what works’ (Creswell, 2003; Tashakkori & Teddlie, 1998) and in the search for truth, qualitative and quantitative methods are not only compatible but more specifically form an enduring partnership (Reichardt & Rallis, 1994 cited in Tashakkori & Teddlie, 1998). From a pragmatic perspective it is not important to seek knowledge and truth that is independent from human experience but instead to achieve a better and more detailed experience. Such a richer experience can not be attained through a single method but instead through any productive combination of methods (Johnson & Onwuegbuzie, 2004; Yardley & Bishop, 2008). The approach addresses concerns of both qualitative and quantitative researchers by acknowledging that interpretation are part of all human inquiry and that values and assumptions must be grounded in empirical, embodied experiences (Yardley & Bishop, 2008). The pragmatic approach is primarily concerned with workable applications and solutions to problems (Creswell, 2003) and fundamental contradictions of objectives and characteristics of qualitative and quantitative research are likely to be of lesser importance, even if methods of inquiry and validation differ (Yardley & Bishop, 2008). Tashakkori and Teddlie (2003) argue that in research it is the research question which is most important and method and theory only take a secondary stance.

The use of both qualitative and quantitative methods from a pragmatic perspective in the current study is based on a shared set of beliefs. These include the belief in value-ladenness of inquiry, the belief that reality is constructed, the belief in the fallibility of knowledge and the idea that any given data set can be

explained by many theories (Tashakkori & Teddlie, 1998). More specifically, scientific inquiry cannot be removed from personal knowledge, vision, and aspirations. Science is a human enterprise characterised more by uncertainty, faith and compassion than neutral objective observation. For that reason it has been suggested that both quantitative and qualitative research methods are crucial as scientific thinking never gets away from qualitative existence. Similarly, knowledge is linked to intentions and actions and takes meaning from the evaluation of its effects (Yardley & Bishop, 2008). This is both a functional and a relativist definition since truth is defined in relation to a particular goal and particular context rather than one ideal of universal truth. Knowledge develops out of actions, situations, and consequences rather than antecedent conditions (as in post-positivism). From a pragmatic perspective, all acts of inquiry are being evaluated in relation to rightness and wrongness to achieve their goal. A test of rightness of methods must therefore refer to the test of external consequences or outcomes. The most relevant outcomes and the best method of evaluating them are based on the type of knowledge concerned (Yardley & Bishop, 2008).

In the current study, the ultimate goal of the inquiry is to identify whether an intervention can improve women's well-being after abuse. While appreciating the distinctive and important contribution of each method, both approaches in the current study have one pragmatic goal and serve one common purpose: to evaluate the effect of Art Therapy for survivors of IPV. Knowledge is therefore concerned with the effectiveness of an intervention to increase positive elements regarded as part of well-being. Effectiveness is appropriately investigated through questionnaires but in order to achieve a richer picture of the effects of an intervention an element of observation and interpretation of participant's accounts

of well-being is necessary. Personal accounts assist in fully understanding the effects of the intervention. Such accounts are concerned with women's beliefs of what it means to be well, and how the perception of their own well-being might have changed during the course of the intervention.

Although the mixing of methods is a result of finding a workable solution to finding tools for the exploration of intervention effectiveness, certain philosophical foundations guide the specific utilisation, analysis and interpretation of methods.

3.2.2.1. Epistemological Position

Epistemology is regarded as the relationship of the knower (the participant) to the would-be-knower (the researcher) (Ponterotto, 2005). In the current study a post-positivist epistemology has been adopted. Much of the psychological research in past decades has been guided by a positivist or post-positivist perspective and is seen as an appropriate framework for mixed method studies using a sequential explanatory design as it is the case in the current study (Hanson et al., 2005). Both positivist and post-positivist researchers focus on cause and effect relationships and by means of research attempt to predict and control phenomena. However, post-positivism is regarded the intellectual heir to logical positivist thinking popular after World War II (Tashakkori & Teddlie, 1998). In comparison to positivists who accept one objective reality, post-positivists acknowledge that an objective reality can only be understood imperfectly as it is impossible to capture one true reality (Ponterotto, 2005). The post-positivist perspective has more and more abandoned any conception of verifying absolute truth, but instead tries to falsify/disprove the current working model of reality (Yardley & Bishop, 2008). In the post-positivist view, research is

always influenced by the assumptions and values of the researcher and is impacted by the hypothesis or theoretical framework used by the investigator (Tashakkori & Teddlie, 1998). Personal biases and subjective experiences are present in the research process and influence outcomes in one form or another. In contemporary research, post-positivist tenets are shared by both qualitative and quantitative researchers (Tashakkori & Teddlie, 1998).

In the current investigation both dualism and an objective stance is advocated throughout the majority of the research process, particularly during phase 1 (quantitative research) of the study. However, in line with the post-positivist perspective it is the researcher's position that bias and subjective experiences are an inevitable influence on the investigation and the outcome. In an attempt to remain objective, the researcher has remained uninvolved in the course of the intervention (i.e. the therapeutic process) to a large extent and only contacted participants before and after the therapeutic intervention. Despite attempts to remain somewhat emotionally uninvolved during the process of collecting and analysing data from participants, it is important to acknowledge the influence of personal values and possible biases on phase 2 (qualitative research) of the study. Instead of ignoring subjective viewpoints during this phase a particular awareness of them is warranted. The decision of using interview data has been influenced by both social activism and the feminist viewpoint underlying much of the work with survivors. One advantage of using interviews is the ability to establish rapport with participants and in turn to be able to ask more detailed and personal questions concerning the participant's experience in therapy. Rapport and understanding of the survivor's situation (and her abuse experiences) are an essential part in this particular project and enable not only the generation of

richer data but were also a significant influence on participant's decision whether to take part in an interview. The emotional involvement with participants is therefore not seen as a negative aspect but rather as an enabling factor in the research process.

3.2.2.2. Ontological Position

Ontology is concerned with nature of reality (Ponterotto, 2005). In line with the post-positivist position, a critical realism stance was adopted in the current study. Critical realists argue that the way facts are viewed, depends partly on the beliefs and expectations of the viewer (Madhill, Jordan & Shirley, 2000). The dominant (i.e. critical realist) belief in the current study informs the assumption that true reality exists but can only be measured imperfectly (Ponterotto, 2005). Further, in an attempt to measure reality it is realised that an inherent subjectivity is part of the production of knowledge (Madhill et al., 2000). This study is therefore an attempt to illuminate an approximal reality of participants' collective experiences with the therapeutic intervention.

The research is also informed in part by contextualism, or the position that all knowledge is local, provisional and situation dependent (Jaeger & Rosnow, 1988 cited in Madill et al., 2000). In the current study, this position supports the idea that findings and outcomes partly depend on stages of change in which women enter into the study and the intervention offered. The contextualist viewpoint informed by a critical realist position allows the researcher to focus on the personal accounts of participants and ground them in social practices and circumstances whose logic and structure can be discovered through empirical enquiry (Madhill et al., 2000).

3.3. The Present Study

The goal of this exploratory research project was to capture changes in participant's well-being quantitatively and qualitatively albeit without interfering in the therapeutic process. Quantitative and qualitative methods are used complementary, one is used to elaborate on the other and a sequential explanatory research design (QUAN → qual) has been employed. The collection and analysis of data was conducted separately, however findings are combined in the discussion section.

The purpose of this two-phase, sequential mixed methods study was to obtain statistical/quantitative results from women who have participated in the therapeutic groups and to explore their experiences in more depth. A longitudinal design has been chosen as it is one of the most powerful designs available for the evaluation of an intervention (Clark-Carter & Marks, 2004). In the first phase of the study, quantitative research questions addressed changes in psychological well-being of women in refuges and outreach centres. In the second phase, systematic questions were asked during qualitative interviews to explore further individual aspects of Art Therapy and Person-Centred Therapy and their value for individual participants as well as therapists.

In the first phase of the study, a pre-test-post-test design was used. A similar pre- and post-test design was used by various other researchers examining the effectiveness of treatment for survivors of IPV (O'Leary et al., 1999) and was chosen to be the most appropriate method for this investigation. Participants were asked to complete a battery of questionnaires at three different points in the study. At time one (T1), baseline data were collected before the intervention. Follow-up data (post-test) were collected twice, at time two (T2), after the intervention (or

after ten weeks for the control group receiving only usual care) and at time three (T3), a follow-up appointment ten weeks after time two. A participant was therefore involved with the researcher for a period for approximately five to six months. In phase two of the study, personal interviews were conducted with participants between the post-test measure and the follow-up contact (i.e. between T2 and T3). The interviews served as a means to explore therapeutic change and participants' experiences with the intervention in more detail. These personal accounts served to elaborate on and explore in more depth findings from the quantitative phase of the study.

3.3.1. Experimental Conditions

Participants were divided into two experimental conditions and one control condition. Women in the control group continued with usual care. Experimental conditions involved one of two therapeutic interventions in addition to continued usual care. Women in the Art Therapy condition participated in group Art Therapy once a week for a period of 10 weeks. Ten sessions have been used by other researchers (Green et al., 1987; Kramer Borchers, 1985) and this timeframe has been chosen in an attempt to offer brief yet sufficient treatment.

Art Therapy consisted of working with a variety of media including drawing, painting, working with collages as well as clay in conjunction with the discussion of participants work, emotional states, traumatic experiences and reactions to abuse. Trauma and emotional states were also part of creative exercises. Participants in the Person-Centred condition received group counselling from a Person-Centred perspective for the same amount of time. Women in this group were given the opportunity to discuss various issues in a therapeutic

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environment similar to the Art Therapy groups but did not utilise any further therapeutic media such as art. The therapy groups were held in a common room within the refuge or the outreach centre. In one case, a room was rented from a church next to the refuge due to lack of space and privacy in the refuge. Closed groups, rather than open groups, which welcome new members at any time, are recommended in the work with survivors (Monnier et al., 2001). Only closed groups were part of the intervention in order to increase participant comfort when disclosing sensitive information. Keeping the groups accessible only to committed group participants also serves as an incentive for participants to attend the required number of hours needed for participation in the investigation. Participation was voluntary but only data of women who participated in a minimum of six sessions were kept for analysis.

All therapy sessions lasted 1 hour and 30 minutes. This time has been recommended in the therapeutic work with survivors (Monnier et al., 2001) and has been used in previous research investigating interventions for women who have experienced abuse (Foa et al., 1991; Maynard, 1993; Rubin, 1991). Thirty additional minutes were given to the Art Therapy groups for preparation and cleaning of the materials. Participants in all three conditions continued their normal routine within the refuge or the outreach centre. These routine interventions included one-on-one conversations with staff members, safety planning, practical help with housing and financial problems, childcare, parenting, legal aid and house meetings with other residents in refuges. Women in the control condition received neither Art Therapy nor counselling from a Person-Centred perspective in addition to routine interventions. Although no additional therapeutic intervention was offered to women in the control condition, the

essential help and attention from professionals (and particularly the assurance of safety) were not compromised or undermined. The work of refuges and outreach centres is crucial. Therapeutic interventions are not intended to take their place but rather, act as an addition. If therapy was required by a participant in the control condition, or in case of an emergency, help was available and women were referred to the appropriate facilities. Information from the participant was then removed from the data base.

3.3.2. Ethical Considerations

The current study was reviewed and approved by the Roehampton University Research Ethics Committee as well as the research ethics committee of the NHS in Lewisham. The latter ethical approval was needed for the work with one Person-Centred group conducted by NHS staff. Data for this study was collected during a period of 20 months, from March 2007 until October 2008. All participants were informed verbally as well as in writing about the purpose of the study, possible implications, the therapy they were to receive (if applicable) and that their participation was voluntary. All participants were knowledgeable about their right to withdraw at any time. Much time was also spent explaining the measures taken to ensure confidentiality. Several meetings were also held with therapists before treatment began. Despite therapist's previous knowledge about domestic violence, the researcher ensured that all professionals were knowledgeable and sensitive to the issues survivors of IPV present. In addition, results of current research on the effects of violence on women as well as difficulties possibly encountered in therapy were presented to each therapist

verbally and in writing. The researcher also ensured that refuge staff were informed about the study as well as the questionnaires given to the women.

Additional ethical considerations were taken into account in Art Therapy groups. Here, the art process, as well as the art work itself, was used as expressions of participant's thoughts and emotions, rather than the symbolic meaning of the images (Smeijsters & Cleven, 2006). Like in any other therapeutic relationship, intimate thoughts and feelings are shared under the assumption of confidentiality. This is not only an important part of verbal communication, but is also the case for client's art work (Hammond & Gantt, 1998). Participants were the owners as well as the keepers of their work. However, the consent form for Art Therapy participants included an option of agreeing for personal creations to be photographed and displayed. Because the appropriate and respectful handling of such documents was crucial, art work was locked away in a safe space between sessions.

3.4. Part 1 – Quantitative Research

3.4.1. Participants

Participants were 51 female adult survivors of IPV from nine refuges and two domestic violence outreach centres in the UK. Participants were selected on the basis of their involvement with either a refuge or an outreach centre. At the onset of the project, the majority of participants were either currently living in a refuge or had recently left a refuge. Women who had left a refuge still utilised the help of a key worker or floating support offered by the refuge. Only six women had never resided in a refuge but utilised the services offered by one of the two

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participating domestic violence outreach centre. Other participants who utilised the services of the outreach centred were also residents of a local refuge. All participants in this study were in the recovery phase after their experience of IPV. When using the Stages of Change Model as a reference, women entered the intervention in the last stages, the maintenance and termination phases, in their process of change. All women were aware that IPV is a crime, that they had been abused by their partners and they had left the relationship to heal from their experience. It is important to recognise the stage participants entered the intervention as the design of therapy catered specifically for this phase in the women's recovery from IPV.

Participants did not receive payment for their involvement in the study however, therapy sessions were of no cost to them or the refuge/outreach centre. Chocolate was given as a small token of appreciation to women in control condition. Potential participants were excluded if they were still involved or lived with their abusive partner. This choice was made since the establishment of safety is crucial and should precede any therapeutic intervention. Women who were not able to write and read English were also excluded as many of the standardised questionnaires were generally not available in other languages. One woman was excluded for that reason, another woman was excluded because she was younger than 18. All other women who expressed sincere interest in participation completed the battery of questionnaires at least once. When the project was introduced in facilities, women were given some time to think about whether they would like to take part or not. Reasons for not participating in the study included reluctance to engage in therapy after having just arrived at a refuge, prospects of

moving out within the near future, and fear of revealing personal information, which included their name and signature on the consent forms.

3.4.2. Therapists

Art Therapists and Person-Centred Therapists were identified through the British Association of Art Therapy, the British Association for Counselling and Psychotherapy and HEVAN (Health Ending Violence and Abuse Now), the National Domestic Violence Health Practice Forum. Recruitment was conducted via personal email or phone contact as well as newsletter advertisements and advertisements through email. Ten therapists (five Art Therapists and five Person-Centred Therapists) were initially recruited but four therapists withdrew before the study began. Reasons for leaving the study were time constraints, death of a family member, and illness. Four Art Therapists and two Person-Centred Therapists remained and volunteered their time and expertise for the project. All therapists who were contacted had been chosen because of their theoretical and therapeutic background. Although Art Therapists are psychoanalytically trained in the UK, many had adopted a Person-Centred perspective in their work. In Person-Centred Arts Therapy, much like in talking therapy, the focus lays the belief that every person has worth, dignity, the capacity for self-direction and an inherent impulse toward growth. In essence, the approach is guided by a deep faith in every person's innate ability to reach his or her full potential. In order to facilitate change, growth and healing in a therapeutic setting the therapist is required to be empathic, open and honest, congruent and caring. Much like set forth by Carl Rogers, the Person-Centred approach in Art Therapy also respects the integrity and self-direction of the client while using art as another language and means of

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expression (Rogers, 2001). In Art Therapy from this perspective the therapist is “a companion on the client’s path of self-exploration” (Rogers, 2001, p.168).

Two therapists led groups twice during the course of the study. All therapists had extensive experience in leading individual therapy sessions as well as in group work. All therapists had worked with vulnerable populations before and were knowledgeable about the area of domestic violence. Additional information about domestic violence and specifically the work with survivors of IPV was obtained from the researcher prior to the start of the therapy sessions. In addition, discussion meetings were held with the researcher and reading material was distributed with the goal of giving therapists an opportunity to review recent findings in the area of domestic violence. Throughout the intervention, the researcher remained in close contact with all therapists and refuge/centre staff.

Five Art Therapy groups in which 19 women participated and three Person-Centred groups in which 14 women participated were conducted. Seventeen women participated in the study as part of the control condition. Only one Person-Centred Therapy group had been organised by the group leader prior to the study. This group was part of an ongoing project (WINGS – Women In Need Growing Stronger, Shropshire). All other groups were organised and implemented by the researcher. Participants were not randomly assigned to groups. The location of the groups depended mainly on the geographic location of either an Art Therapist or Person-Centred Therapist. The location of the groups was further dependent on the level of interest from service users and staff members.

3.4.3. Steps of Recruitment

Managers or Directors of thirty refuges were initially contacted by the researcher and informed about the purpose of the study. Initial contact was then followed up by personal meetings or in rare cases, phone conversations with Managers or staff members. A final preliminary meeting was then organised with additional members of staff and residents at each refuge in order to present the purpose of the study to staff and potential participants. Similarly, both outreach centres were contacted by phone and visited in person. A presentation of the research project was then also held for staff and potential participants at the centre. The presentation focused only on the therapy condition which could realistically be held at the respective location (depending on the proximity of a therapist). As a result of these presentations, 78 women overall expressed interest in participating in the study. Thirty seven women were interested in attending an Art Therapy group, 20 women wanted to take part in a therapy group from the Person-Centred perspective and 21 women expressed interest in taking part in the study without attending a therapy group. Participants in this control condition understood that therapeutic services were evaluated in this study and that although no additional therapy was offered, the routine interventions within refuges are an important part of the investigation.

Of the 78 women who had expressed initial interest, 51 began their involvement in the study and completed the baseline measures. The number of participants in previous studies of a similar nature varied greatly. Because much of the literature involved case studies or qualitative analysis, large groups of participants are rare. In comparable empirical studies investigating the effectiveness of a therapeutic approach for survivors of domestic violence the

numbers of participants ranged from five (Colosetti & Thyer, 2000) to 125 (Kubany et al., 2004). Although ideally a greater number of participants, between 25 and 30 for each experimental condition, should be sought, the recruitment of this number of participants was not realistic/feasible in the given time frame. At the beginning of the project it was the researcher's ambition to recruit 10 to 15 participants for each of the three conditions.

3.4.4. Procedure

After the organisation of intervention and control groups with respective refuges/centres, various meetings were held with Art Therapists and Person-Centred Therapists both individually and as a group in order to discuss the course of therapy as well as relevant issues regarding domestic violence. It was the researcher's initial ambition to devise a therapy manual in collaboration with the therapists involved. However, it was strongly felt that manualising ten weeks of therapy would stifle the therapeutic development and natural flow of the sessions. It was agreed that in line with the Client-Centred approach, group members should be encouraged to bring their own topics, concerns and issues to the group. It was therefore agreed that session notes outlining weekly therapy themes would be recorded after each session by therapists and kept so that a retrospective comparison between the groups was possible and some consistency could be established. Although all therapists had been asked for notes, not all were able to fulfil this request. All available session notes were analysed and weekly themes extracted. A list of therapeutic themes can be found in Appendix D. The reluctance of therapists to engage in the creation of a 'one-size-fits-all' (generic) manual was somewhat expected. The lack of a group outline or specific

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techniques used by all therapists is part of research with less strictly controlled research conditions. Although this lack of a manualised intervention can be seen as problematic for the research, it reflects the reality of clinical practice. It has also been noted that the presence of a manual does not automatically guarantee equal quality among groups and therapists (Goldfriend & Wolfe, 1998). The comparison of session notes and topics discussed in all therapeutic groups is an attempt to counteract this difficulty and to inform future research of this nature. The multi-faceted structure of the therapy groups are therefore of particular interest as they reflect therapeutic intervention with survivors in a real-world setting.

Preliminary meetings with service users and staff served the purpose of presenting the research project and its purpose and to discuss the experience of taking part. Confidentiality and limits to confidentiality as well as the right to withdraw from the study at any time were discussed at that time with all potential participants. These informative meetings also gave women the opportunity to raise questions or concerns. Preliminary meetings were also held to assess the level of interest and potential dates and times available for therapy. Therapy groups were then organised in collaboration with both the therapists and members of staff at refuges or centres. After finalising the organisation of the therapy groups, letters of invitation to the therapy, including final dates and times, as well as an invitation to a coffee morning were sent out again to each resident of the refuge or each interested service user in participating centres. An example of an invitation can be found in Appendix A. Flyers with details about the therapy groups and questionnaire meetings for use on the refuges' and centres' bulletin boards were also sent to staff members to remind women of upcoming events. A

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coffee morning or informal meeting was organised for all participants so that the first battery of questionnaires (at T1) could be completed. It was found that an informal meeting such as a coffee morning resulted in greater interest from participants and functioned as a motivator to complete the questionnaires. As some questionnaires require specific instructions and questions were often raised about their completion, the researcher was nearby and available to deal with any queries or concerns. An additional information sheet explaining the study, confidentiality, and the right to withdraw was part of the questionnaire packet and was retained by participants. The questionnaire packet also included the researcher's contact information as well as the Consent Form, which was explained to participants prior to the completion of the questionnaires. A contact sheet was also included in the package in an attempt to ease communication between the researcher and the participants in the upcoming weeks. If a participant was not able to come to the coffee morning/questionnaire meeting but wanted to participate in the study, a later meeting was arranged or detailed instructions were given to refuge staff and the package was then completed by the participant in her own time to be picked up by the researcher at a later time. An example of the questionnaire package and consent forms can be found in Appendices B and C respectively. The completion of the questionnaires took participants between 50 to 90 minutes.

During the ten week course of therapy, the researcher remained in close contact with the therapists and members of staff at refuges and centres. Although no contact was made with participants during this time, the progress of therapy was monitored through regular email and phone contact with therapists and staff members. In case difficulties or concerns arose between therapists and staff

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members they were immediately discussed and, if possible, amended.

Approximately two weeks prior to the end of therapy, a second letter was sent to participants to remind them of any arrangements made to complete the questionnaire package for the second time (T2). A further meeting was organised with refuge staff for that purpose and flyers were again sent with details of upcoming meetings. As refuge staff were aware of the general schedule of residents, attempts were made to accommodate and respect each participants time and outside commitments when organising the meetings.

Eight weeks after post-test (T2) questionnaires were completed, women were sent a third letter as a reminder of the final time for questionnaire completion. Refuges were also contacted to ask for permission for a third informal meeting with participants and to investigate whether all or some participants still resided there. Some women had moved on at the time of the last meeting and were contacted personally when possible. A personal meeting was then arranged or addresses were exchanged so that questionnaires could be sent by mail. A stamped (freepost) return envelope was included in the package in each case. Personal “Thank you” letters were included in each final package and sent to participants by mail after their involvement if a personal meeting was no longer possible. An example can be found in Appendix A.

Because confidentiality is a primary concern with survivors of IPV and for the refuges and centres working with them, all organisation and implementation of therapy groups as well as the collection and analysis of quantitative and qualitative data was the sole responsibility of the researcher. Being allowed access into the refuges was respected by involving only a few individuals (i.e. the

therapists) and by not sharing any information about the location of the refugees or about the residents.

3.4.5. Materials

In order to detect improvement across different domains after the therapeutic interventions, multiple measures were taken during phase one of the study. The dependent variable (psychological well-being) was measured quantitatively. Six standardised questionnaires were utilised, which did not change during the course of the investigation. The questionnaires focused on previously outlined measures of mental health difficulties often experienced by survivors of IPV. Further, and possibly confounding, variables included socioeconomic status, time since leaving the abusive relationship, length of the abusive relationship, prior therapy experience, medication and education as well as occupational status. These variables were measured once and included as items on the socio-economic form. The battery of primary outcome measures included the Rosenberg Self-esteem Scale (SES) (Rosenberg, 1965), the Beck Depression Inventory II (BDI-II) (Beck, Steer & Brown, 1996), the Symptom Checklist (SCL-90-R) (Derogatis, 1992), the Trauma Symptom Inventory (TSI) (Briere, 1995), the General Self-efficacy Scale (GSE) (Jerusalem & Schwarzer, 1993) and the Coping Responses Inventory (CRI) (Moos, 1993). A copy of questionnaires can be found in Appendix B.

The Rosenberg Self-Esteem Scale (SES) was originally developed to assess self-esteem in adolescents but is now one of the most widely used measures of global self-esteem in both young people and adults. The SES is a 10-item self-report questionnaire assessing general feelings of self-worth and self-acceptance.

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Participants are asked to rate each item on a 5-point Likert scale ranging from “strongly agree” to “strongly disagree”. Typical items are “At times, I think I am no good at all” and “I take a positive attitude toward myself”. The scores are added after reverse scoring of positively worded items. Final scores range from 0-30. Scores between 15 and 25 are within normal range and scores below 15 suggest low self-esteem. This measure is considered highly reliable and valid. Internal Reliability in the general population for the English version of the scale in the UK is .90 (Schmitt & Allik, 2005). The SES has demonstrated good internal reliability in previous research with survivors of IPV), ranging between .86 (Cascardi & O’Leary, 1992) to .92 (Saunders, 1994). The SES has been used frequently in research with survivors of IPV (Saunders, 1994, Clements et al., 2004; Cascardi & O’Leary, 1992; Katz, Arias & Beach, 2000, Lewis et al., 2006) and was therefore chosen as part of the test battery in the current study.

The Beck Depression Inventory (BDI-II) (Beck, Steer & Brown, 1996) is a multiple choice self-report questionnaire with 21-items to assess dysphoria and severity of depression. The BDI and its revised version BDI-II have been widely used as an assessment tool in health care settings for 25 years and the scale is one of the most frequently used measures to investigate depression among survivors of domestic violence (Cascardy & O’Leary, 1992; Saunders 1994; Bogat et al 2005; Sackett & Saunders, 1999; Campbell & Soaken, 1999). Participants are asked to chose an answer which best describes how they felt during the past two weeks. Each question has a set of four possible answers which range in intensity. For example: (0) “I do not feel sad”, (1) “I feel sad much of the time” (2) “I am sad all the time”, or (3) “I am so sad or unhappy that I can't stand it”. A final score is derived from summing all 21 items. Score can range from 0 to 63. Score

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from 1-13 indicates no or minimal depression, 14–19 mild depression, 20-28 moderate depression and 29-63 severe depression. Higher total scores indicate more severe depressive symptoms. It is considered to be both reliable and valid for that population, internal consistency scores ranging from .82 (Cascardy & O’Leary, 1992) to .93 (Houry et al. 2005 (Clements, Sabourin & Spiby, 2004).

The Symptom Check List (SCL-90-R, Derogatis, 1992) is the only questionnaire in this battery of tests to identify general psychological well-being and psychopathology. It is also useful as an instrument measuring progress or treatment outcomes. The 90 items in this self-report questionnaire are designed to show patterns of symptoms using a 5-point Likert scale. Nine symptom scales including Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation and Psychoticism are used to provide information on symptoms of various primary symptom dimensions. The additional indices give a general overview of psychological distress, the intensity of symptoms as well as the number of self-reported symptoms. Participants are instructed to rate how much a problem has distressed or bothered them during the past week. Typical items include “Feeling that most people cannot be trusted” and “Spells of terror or panic”. The scores can be illustrated and converted into T-scores on a worksheet. The test has been used with a variety of populations including victims of rape (Resick, et al., 1988; Cryer & Beutler, 1980) as well as survivors of IPV (Mitchell et al, 2006; Dutton et al, 1994; Arias & Pape, 1999; Woods, 2000). The instrument has been deemed reliable and valid in previous studies with Cronbach’s alpha ranging from .81 to .93 (Mitchell et al., 2006).

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The Trauma Symptom Inventory (TSI, Briere, 1995) is a questionnaire designed to measure a range of acute and chronic post-traumatic symptomatology. Ten clinical scales focus on anxious arousal, depression, anger/irritability, intrusive experiences, defensive avoidance, dissociation, sexual concerns, dysfunctional sexual behaviour, impaired self-reference, and tension-reduction behaviour (Briere & Elliot, 1997). All are symptoms closely related to symptoms described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Three additional validity scales measure exaggerated, inconsistent and unusual responding. The instrument has been evaluated and was found to be highly valid and reliable (McDevitt-Murphy, Weathers & Adkins, 2005). The mean reliability coefficient of this inventory for the clinical scales is .86 (Briere, 1995). Participants are instructed to indicate how often an experience has happened to them within the last six months using a 4-point Likert scale. Experiences include “Fainting”, “Nightmares or bad dreams” and “Being startled or frightened by sudden noises”. Although the TSI is a more recent instrument, it has been used frequently in research with survivors of domestic violence (Gorde, et al, 2004; Lindgren & Renk, 2008) and sexual abuse (Briere & Elliot, 1993) and has been advocated a promising tool to understand and assess particular symptoms resulting from the abusive experiences (Housekamp, 1994). Further, the use of the TSI, SCL-90-R and the BDI have been supported by several researchers (Monnier et al, 2001) as very useful assessment tools when investigating effectiveness of group interventions for survivors of IPV.

The General Self Efficacy Scale (GSE, Jerusalem & Schwarzer, 1993). Self-efficacy is regarded as an individual’s belief in their ability to perform a variety of novel or difficult tasks as well as their ability to cope with hardship.

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Schwarzer and Scholz (2000) write that a person who believes herself to be able to create a desired outcome is also able to lead a more active life and is more self-determined. Low self-efficacy is associated with depression and anxiety. The scale developed by Jerusalem and Schwarzer in 1979 is designed to measure a general sense of perceived self-efficacy. The authors aimed at predicting coping with daily obstacles as well as adaptation after experiencing stressful life events. The operative construct of perceived self-efficacy is thought to facilitate goal-setting, effort investment, persistence and recovery from setbacks. The General Self-Efficacy Scale is a self-report measure and consists of 10 items that rate a person's self-efficacy on a 4-point scale. Typical items are "Thanks to my resourcefulness, I know how to handle unforeseen situations" or "I can solve most problems if I invest the necessary effort." The scale is quickly completed and scored. Final scores range from 10 to 40. The questionnaire is available in 26 different languages and is considered to be highly reliable and valid. According to the authors, in samples from 23 nations, Cronbach's alphas ranged from .76 to .90, with the majority in the high .80s (Schwarzer & Jerusalem, 1995). The scale has been chosen due to its wide applicability into such domains as the investigation of adaptation after life changes, such as separating from an abusive partner, as well as an indicator of quality of life at any point in time.

The Coping Response Inventory (CRI, Moos, 1993) is a measure used to examine a person's coping approach and skills after stressful life events or challenges. More specifically, this instrument measures eight different types of coping responses including approach, or problem-focused coping (such as logical analysis, positive reappraisal, seeking guidance and support, problem solving) and avoidance coping (including cognitive avoidance, acceptance or resignation,

seeking alternative rewards and emotional discharge). These eight types reflect focus- and method of coping (Moos, 1993). Participants are asked to think about how important problems are managed and respond to 58 questions about behaviours concerning an important problem within the past year. Answers range from 'not at all' to 'yes, fairly often'. The CRI has been used with a variety of populations including substance abusers (Humphries et al., 1999), older problem and non-problem drinkers (Moos et al., 1990) and in research on depression and anxiety (Blalock & Joiner, 2000).

3.5. Part 2 – Qualitative Research

3.5.1. Theoretical Perspective

While the focus of the first phase of this study focussed on changes in well-being and symptoms of depression and PTSD, the second phase of the study was concerned with further, and so far undetected, elements of change or benefits of the intervention for individual participants. This phase of the research project was therefore concerned with personal accounts of participants' experiences in therapy. The qualitative part of the study was guided by how the participant experienced and perceived her participation in therapy. Questions asked were influenced by thoughts on how participants process and perceive Art Therapy as part of their treatment after the experience of IPV? Qualitative methods of data collection and analysis have been chosen to explore the meaning of the intervention for survivors. The above mentioned methods of inquiry including the use of diagnostic criteria in the first phase of the study do not allow exploration of unique dynamics or aspects that might be relevant in either or both interventions

(Art Therapy and Person-Centred Therapy). Although the post-positivist perspective is the dominant framework in the current study, qualitative methods are used to highlight, explain and further elaborate on the findings of the questionnaire data. In addition, the use of qualitative methods takes the social and political context of IPV into account, which would not be possible through the sole use of quantitative means. The qualitative techniques employed in this phase to enhance the idea of Person-Centredness and are not meant to be critical of the positivist stance adopted in the quantitative part of the study. Rather, qualitative research in this study acts to help interpret quantitative findings.

There are several reasons why qualitative methods have been chosen in addition to quantitative measurement in the current investigation. Qualitative research can easily take place in a natural setting, such as the participant's home (the refuge) which aids in establishing rapport and a closer relationship between researcher and participant. Due to this relationship, more personal and detailed concepts can be explored and a deeper level of detail about the experience can be developed. For example, in the current study empathy and a common understanding of violence against women as a crime are used as a bridge between researcher and participant.

Knowledge developed in this phase of the investigation is expected to be emergent rather than prefigured (as in the quantitative part) and therefore allows the researcher to discover and develop emerging new themes about a particular kind of therapy. In addition, information from participants enables the researcher to understand a broader view of the phenomenon studied and in this way adds to a holistic picture of the effects of an intervention. Most importantly, qualitative research uses methods that are humanistic and take into account, even focus on,

the important involvement of participants in the study (Creswell, 2003). The feedback from participants is central to this investigation because of the social and political issues connected to this area of research. The choice of using qualitative methods in the current study has been influenced in part by researchers endorsing the advocacy/participatory approach. Advocacy researchers believe that research should contain an action agenda for reform that may change the lives of marginalised individuals (Creswell, 2003). Particularly in feminist research it is felt that positivist and post-positivist research impose limits to research that does not fit marginalised individuals or groups. Hence, important political issues and social injustice are frequently not addressed through quantitative research. Although the current investigation does not focus on social activism and on bringing about social change, it was felt that political issues cannot be ignored in the work with survivors of IPV. Counselling as a field has a commitment to social justice (Goodman et al., 2003) which also differentiates the profession from other mental health specialities like psychiatry and clinical psychology. Empowerment is one of the most prominent and crucial goals of therapy with survivors and qualitative approaches can assist in finding out which approaches are actually empowering to survivors.

Individual interviews were conducted as a method for understanding the effects of the intervention from the participants' points of view. Similar to feminist research, this study takes survivors' diverse situations into account. In studying the effects of therapy, it is important to recognise that survivors of IPV are not a homogenous group and a 'one size fits all' approach might not be successful. An approach using practical aid in combination with effective therapeutic intervention and opportunities for empowerment might most likely

yield positive results. The aim of the qualitative phase of this study is to explore in what ways Art Therapy can be effective and empowering to survivors.

3.5.2. Participants

Participants included in this second phase of the project were part of the cohort from the first (quantitative) phase of the study and were recruited through the intervention groups they had attended. A letter of invitation to a personal interview to discuss individual experiences in therapy was included in the questionnaire packet at data collection time two. The purpose and details of the interview were further explained when participants met to complete the questionnaires after the intervention. Nine women who participated in the intervention groups agreed to talk to the researcher in a personal interview. Five interviewees had attended an Art Therapy group and four were members of a Person-Centred Therapy group. Participants were interviewed in the refuge or outreach centre or met with the researcher in a public place such as a park. For one interview, a room was booked in a local library. The interviews lasted between 30 and 50 minutes and were recorded and later transcribed by the researcher.

According to Maykut & Morehouse (1994) interviews are a conversation with a purpose. The purpose of the interviews was to explore participants' personal experiences in the intervention groups and gave participants the opportunity to elaborate on the client-therapist relationship. A focus of the interviews was also any potential intrapersonal or interpersonal change as participants saw it. It is hoped that these reports will complement and detail the results of the quantitative investigation and if possible give rise to information

about changes which might differ from those assessed by the quantitative measures in phase one. Interview questions were semi-structured and based on four elements: expectations of the group, attitudes about the intervention, outcomes and the therapeutic relationship. An outline of the general interview schedule can be found in Appendix E.

3.5.3. Method of Data Analysis

Data resulting from personal conversations were examined through thematic analysis. Thematic analysis is a newly emerging, contemporary approach to qualitative analysis in psychology and is sometimes considered a form of grounded theory (Brown & Locke, 2008). It has recently been brought to the forefront of qualitative research by Braun and Clarke (2006) as a widely used yet rarely acknowledged method of analysis in psychology. In essence, thematic analysis is a method for identifying, analysing and reporting patterns within data (Braun & Clarke, 2006). Similar to content analysis, thematic analysis is concerned with purely the topic rather than nuances of language as in discourse analysis (Brown & Locke, 2008). In general, themes of interest are found through a detailed investigation of the data, i.e. line by line reading and coding, so that the emerging topics can be placed into larger categories/themes and sub-themes (Brown & Locke, 2008). It has been the approach of choice for many contemporary researchers because of its flexibility and its ability to allow for social as well as psychological interpretation of interview data. It has been suggested that the reason for the increasing popularity of thematic analysis particularly in health-related fields is their “ability to sidestep tricky epistemological concerns regarding constructionism or interactionism” (Brown &

Locke, 2008, p. 382) and are practical methods for analysing qualitative data in applied and practical research. Thematic analyses are often combined with quantitative research and are useful in research studies which are more quantitative in nature as is the case in the current project. The focus of the qualitative interviews in the current study was not on the use of language but on common themes that can inform future therapeutic interventions for survivors of IPV, hence a constructionist approach to data analysis would have been inappropriate.

Thematic analysis is thought to be the foundation method for most qualitative analyses and forms the basis of further diverse and more complex methods such as Interpretive Phenomenological Analysis (IPA) and grounded theory. The drawing out of themes in any qualitative inquiry is seen as one of the generic skills across all qualitative analyses and Braun and Clarke argue that this flexible approach is despite its rare status “a method in its own right” (Braun & Clarke, 2006, p. 78). In the current study, thematic analysis is used from a realist perspective. The researcher remains cognizant of the fact that qualitative data is interpretive and therefore filtered through a personal and subjective lens. A combination of critical realist and contextual understanding of data serves to discover the underlying structure of participants’ personal accounts while keeping in mind that knowledge produced by the researcher from the accounts of the participant is situation specific. From a contextual position, such personal as well as additional cultural perspectives play an important role in the analysis (Madill et al., 2002).

3.5.4. Process of Analysis

Interviews were recorded and later transcribed by the researcher. All interviews were saved as Microsoft Word documents. The focus of data analyses was a pragmatic one. Steps in performing a thematic analysis have been derived from Braun and Clarke (2006) and Aronson (1994). During the first phase of the analysis, transcripts were individually read and re-read to gain an understanding of patterns of experiences or common ideas that might form the basis for repeated themes. Sentences were coded to assist in the process of classifying patterns and themes. Coding was in part theory driven, i.e. derived with specific ideas about the outcomes of the interviews in mind and all items, depending on the outcome of phase 1 of the study – the quantitative analysis. All data related to such a classified theme were then identified and marked and quotes were extracted to underline and support them. After a repeated coding of all transcripts and the search for themes, related patterns were then combined and catalogued into sub-themes, also identified as theme-piles by Braun and Clarke (2006). Themes and sub-themes were then subjected to a consistent review and refining process until themes satisfactorily represented the meaning of the data set. A comprehensive picture was then formed to describe participants' experiences in therapy.

CHAPTER 4 RESULTS

4.1. Difficulties encountered

The implementation of the therapeutic intervention that was a crucial part of this research project was not simple or effortless in all cases. A variety of difficulties were encountered in the process of this research project, spanning from the planning stages, implementation, to the end of data collection. These challenges not only shaped the implementation but also the analysis and therefore the results of this project. A brief account of the problems experienced is included in the thesis to help provide a better foundation for future projects of a similar nature.

Challenges in the work with survivors of intimate partner violence are mainly due to the complex nature of the problem. The lives of women in refuges might be unpredictable or chaotic and treatment, as well as research, is not always a priority for residents (Monnier, Briggs et al. 2001). Refuge staff also tend to deal with a variety of difficulties. Agencies often have a high work load including unplanned interruptions such as crisis intervention, and may be understaffed at the same time. Additional obligations to the daily routine, such as meeting with researchers or implementing a research project, can therefore prove to be a hard to manage challenge for refuge workers.

At the planning stage of this project, attempts were made to make contact with as many refuges as possible. Due to reasons of confidentiality, gaining access to refuges was taxing. Because domestic violence agencies, and refuges in particular, are not publicly known, contact details of refuges were found through personal connections with professionals in the field or through internet research. A preliminary call provided a basis for understanding the availability, interest in and

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feasibility of implementing the research project in refuges. Understandably, many refuges did not wish to be part of the project for reasons of confidentiality. Both, the researcher or the therapist working with women, present a potential risk of making the safe location known to others. A lack of time and available space were also reasons for declining the offer of collaboration with the researcher. Once access to refuges was granted, finding a suitable time to fully explain the research and its purpose to staff members or potential participants was rare. This was mainly due to the high work load as well as the high turn over rate of staff members, resulting in many journeys to present the research project in refuges – at times in vain despite pre-arranged appointments. For the same reason, finding a contact person within the refuge was challenging at times resulting in unreturned phone calls, long waiting times for decisions, misplaced letters as well as a lack of communication with the researcher. Because of the high turn over of staff, the person available and responsible for the work with the researcher and the project was on some cases no longer available several weeks later. The new staff member in her role was then usually not informed about the research or what the implementation would mean for staff members. It was also found that finding staff members who would be willing to make a commitment to the research project throughout its entire duration (including the time of follow-up data collection) is as crucial as finding an interested response to the suggested research project in the beginning.

A number of preliminary meetings to present the research to residents was also organised in all refuges or agencies which had agreed to take part. Considerable time was spent organising such meetings, which were usually kept informal and pleasant. Often, “coffee mornings” were used for this purpose and

tea as well as cake or biscuits had been brought in by the researcher. The success of such meetings was highly dependent on the interest and involvement of staff members in the project. It was found that when professionals understood and valued the project, residents were also keen to find out more and to participate. In such cases, the researcher's flyers were hung up in places frequented by residents and the project was put on the agenda of weekly house meetings. A lack of interest, availability or time however meant that very few women attended these coffee mornings. Often messages or flyers were not passed on to residents or women reported that they simply had "something better to do".

Most refuges, and particularly those outside of London, are small, thereby naturally limiting the number of women who may participate in research. Although bigger refuges also tended to yield a better access to participants, a greater number of residents presented a variety of other problems. It was experienced that internal 'social grouping' influenced who chose to take part and who could not. Being singled out for example, or belonging to another group within the same refuge, made participation difficult for women who might be interested in the intervention but did not get along with other women already taking part. Many interpersonal problems impacted the commitment to the group.

Difficulties also entailed the implementation of an intervention. The course of therapy had to be greatly improvised at times as it did not belong to the regular routine of refuges. For example, because therapy rooms were not usually available, other common rooms such as the children's play room or the living room had to be used during the sessions. Often, this created confusion and frustration for staff members usually working in these rooms or for those women who did not want to participate in therapy but usually used these common spaces.

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Additional problems with a non-designated Art Therapy room are lack of storage areas for materials as well as art work between sessions, inappropriate tables (often not the appropriate size or height), dependence on key holders if the session is held outside the refuge, possibly a lack of light and warmth, and privacy. A further challenge was the organisation of child care. Although many refuges have a staff member working with children, her availability varied and was rarely compatible with the time of therapy. The lack of child care caused some women to withdraw from treatment. Interruptions during the therapy sessions because of child care issues were also common.

As mentioned previously, the lives of women after the experience of violence are often chaotic and may be dominated by fear and a wish to regain control over one's life. When considering survivors of intimate partner violence as research participants, it is crucial to consider the negative mental health consequences of abuse as well as the difficulties experienced in the challenging situation in which women find themselves. Difficulties include multiple stressors that exist after women leave a refuge in addition to mental ill health, such as contact with the abusive partner, financial or legal problems, cultural expectations, previous experience with violence in their family of origin, etc. Many women leave the refuge prematurely for a variety of reasons, making continual treatment difficult. Therapy sessions might be cancelled or simply missed frequently and attrition is high in therapeutic groups. The seeming lack of commitment might also be mistaken for non-compliance or disinterest.

Many women were ambivalent towards the participation in research. Reluctance to take part in the study was driven by the fear of being found or discovered. Although much effort has been spared to make questionnaires as

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confidential as possible, for some women, the release of any personal information was too much. This was a most prominent problem when it came to signing consent forms. Understanding these difficulties in commitment is crucial in avoiding much frustration in research as well as treatment.

An initial acknowledgment of the importance of treatment and explicitly stated interest was high for almost all women questioned at the onset of the project. Although this majority of residents in turn also agreed to take part, very few women attended the first group session. Some also dropped in and out of sessions in an informal way. Similar problems were ongoing throughout the project and included difficulties in questionnaire completion and consistent no-shows for data collection appointments, in particular if women had moved out of the refuge before the last follow up measurement. In such cases, contact was usually lost despite careful attempts to stay connected. Completion of questionnaires caused much frustration for both participants as well as therapists. Participants disliked completing the questionnaires and many discussions regarding the questionnaires took up valuable therapy time. Despite numerous explanations from the researcher, women often wondered about the point of the questionnaires. Most women felt that the questionnaires were too personal, inappropriate, disrespecting, invasive, insensitive to their issues or created a school-like atmosphere and participants used a variety of excuses to avoid completion. In personal conversations, several therapists suggested that using questionnaires (particularly those with such a personal content) could have been counter to the idea of the client-directed approach. While most participants understood the value of questionnaires as a method to compare groups, many

women did not understand the reason for completing such extensive measurements.

It is not always the work with clients but also the collaboration with therapists that can create problems. The empirical approach used in the research project often clashed with the work of professionals in the field. Research methods (and in particular questionnaires) were thereby frequently a point of disagreement. Although research is inherently subject to problems and investigations with individuals in the ‘real world’ will always encounter real life problems, an awareness of a pattern of issues might make the construction and implementation of future designs more successful. It is hoped that the brief outline of difficulties encountered can pave the way for a smoother research process for future projects. An awareness of the challenges could make an implementation of future interventions less challenging, because when the therapy was implemented and participants actively took part, the project yielded several fruitful results.

4.2. Results of the Quantitative Analysis

The purpose of the quantitative analysis was to investigate the effects of three interventions for survivors of IPV in regard to self-efficacy, self-esteem, depression, general psychological well-being, coping and symptoms of PTSD. This study explored the effects of two interventions on psychological well-being of IPV survivors. These effects were measured by changes in participants’ scores across three time points: baseline (T1), post-intervention (T2) and follow-up (T3). Results of all relevant statistical analyses will be described in the following section.

4.2.1. Demographic Profile of Sample

Fifty one women participated in this study. Allocation to intervention groups and control group was not by random but by self-selection. Nineteen women (37.3%) agreed to participate in the art therapy sessions, 14 (27.5%) women agreed to take part in person-centred therapy sessions and 18 women (35.3%) participated in the study as part of the control group.

4.2.1.1. Age

In order to provide a greater level of confidentiality, participants were asked to indicate the age group to which they belonged, rather than their exact age. The largest percentage of participants (62%) was between 23 and 37 years old. Numbers of participants in each age group are presented in Table 1.

Table 1

<i>Age Groups of Participants</i>					
Age group	<i>N</i>	%	Art Therapy	Person-Centred Therapy	Control Group
			n (%)	n (%)	n (%)
18 – 22	3	6	1 (5.3)		2 (11.1)
23 – 27	13	26	3 (15.8)	2 (14.3)	8 (44.4)
28 – 32	8	16	3 (15.8)		5 (27.8)
33 – 37	10	20	2 (10.5)	6 (42.9)	2 (11.1)
38 – 42	4	8	4 (21.1)		
43 – 47	2	4	2 (10.5)		
48 – 52	3	6	1 (5.3)	1 (7.1)	1 (5.6)
53 – 57	6	12	2 (10.5)	4 (28.6)	
58 – 62	1	2		1 (7.1)	
Total			19 (94.7)	14 (100)	18 (100)

For the additional exploratory analyses, age groups were collapsed into two separate stages: young adults including ages 18 to 32, and older adults including ages 33 and above. Both categories are presented in table 2.

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Table 2

Representation of Age Groups in Intervention Groups

	Art Therapy Condition	Person-centred Condition	Control Condition
Younger adults	7 (14%)	2 (4%)	15 (30%)
Older adults	11 (22%)	12 (24%)	3 (6%)

Note. Number of participants (and percentages)

Chi square explorations were used to investigate the age differences between groups. A significant difference in age between the three intervention conditions was found. Pearson Chi square = 15.98, $df = 2$, $p = .001$. In the Person-Centred condition, 24% of participants were older, whereas only 6% of participants in the control condition belonged in the category of 'older adults'. However 30% of women in the control condition were younger women and only 4% of young adults participated in the Person-Centred group. The majority of women in the control condition were therefore considerable younger than women in the therapy conditions, particularly in comparison to the Person-Centred condition. There is no indication in the literature that age in adult clients impacts therapy outcome (Haddock et al., 2006). However, in the current study, biological age might be confounded with time spent in an abusive relationship. A separate analysis, taking into account the time women spent with their perpetrators, has been conducted and will be discussed at point 4.2.1.6.

4.2.1.2. Ethnicity

The majority of participants were White (White British and other White background). There were no differences in ethnicity between the three involvement groups. Table 3 presents the number of participants in each ethnic group.

Table 3

Ethnic Background of Participants

Ethnicity	n	%
White British	20	39.2
White Other	9	17.6
Mixed	1	2
Asian or Asian British	4	7.8
Black or Black British	13	25.5
Other	2	3.9
Missing	2	3.9
Total	51	100

4.2.1.3. Education

The majority of participants (48.7%) had a Secondary School (GCSE or A-level) education, 7.3% had graduated from college. 14.6 % however had no educational qualification and 17% a vocational qualification (NVQ). In a comparison between groups education was collapsed into two categories, “no qualification to GCSE” and “A level to third level education”. There was no difference between the groups in regard to education.

Table 4

Education of Participants

Education	n	%
No education	6	11.8
Basic Education or Vocational Degree	12	23.5
A level/GCSE	20	39.2
Higher Education	3	5.9
Missing	10	19.6
Total	51	100

4.2.1.4. Occupation

Categories for exploring the occupation of participants were taken from The Job Dictionary (MRS, 2006). The following categories were used in the description: category A refers to the highest level of non-manual workers, B includes executives and managers, C1 includes small business owners and managers, C2 refers to occupations of skilled manual workers, D is comprised of semi-skilled or unskilled manual workers and E refers to individuals who are unemployed or otherwise dependent on benefits. Twenty five percent of participants were unemployed or dependent on benefits whereas 10.4% were in a managerial or executive roles. 14.6% were small business owners or in non-manual jobs. The remaining 50% were manual workers. Figure 4.1. illustrates participants' occupational groups. No differences between the three intervention groups were found on this variable.

When asked about the occupation of members of the family of origin, participants reported that only 10% of mothers were in a managerial or executive role. 52.5% of mothers were in an unskilled manual worker role or dependent on benefits. Fathers on the other hand were reported to be 14.6% in managerial roles and none dependent on benefits or unemployed. The majority of fathers (60.9%) were skilled manual workers, managers or small business owners.

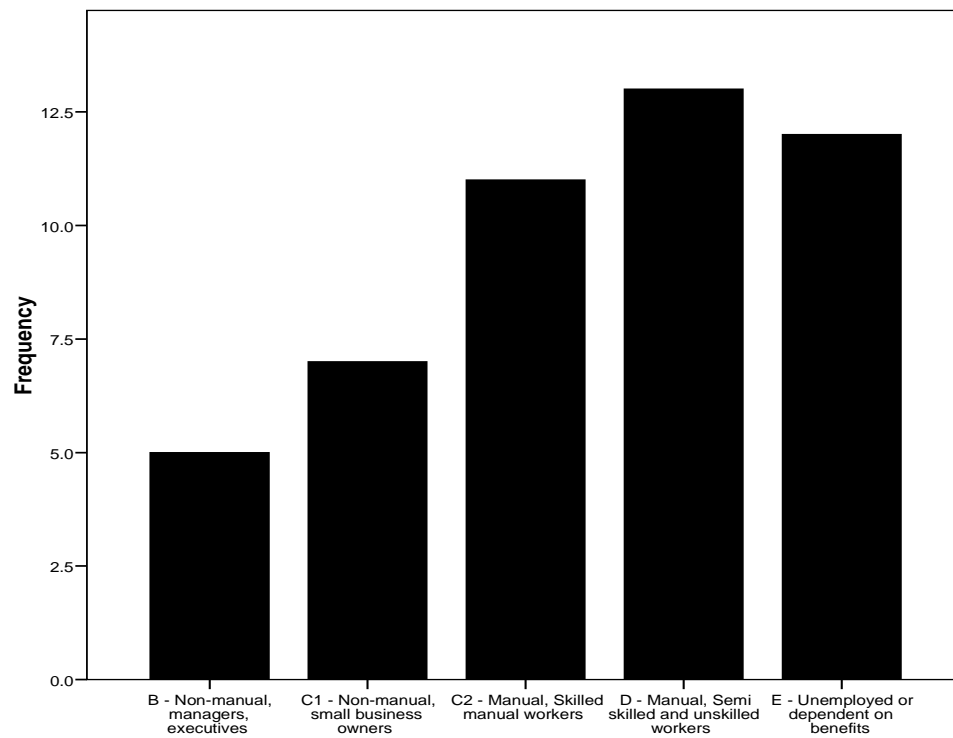


Figure 4.1. Participant's Occupational Groups

4.2.1.5. Children

Ten percent of participants were childless whereas 60% had one or two children. Ten percent of women (5 women) had four or more children and 20% had three children. There were no significant differences on the number of children women had between the three conditions

4.2.1.6. Marital status

Levels in this category included “single”, “married”, “separated”, “divorced” and “other”. Because one inclusion criterion for the study was the separation from the abusive partner further levels were excluded from the questionnaire. At the time of baseline data collection all participants had ended the relationship and were not currently living with their partners. Four percent of

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participants however considered themselves still married, while 45% had officially separated from or divorced their partners. Table 5 shows the relationship or marital status of participants in more detail. No difference was found between the groups at baseline in this category.

At the time of the study, 25 women (34.7%) had left their abusive partners more than 12 months before taking part in the study, 51% had separated several months prior to participation. Only 12 percent had left their partners several weeks previously. The reason for this large difference in time since leaving will be discussed in more detail in section 5.1. One participant took part in the baseline data collection even though she had separated from her partner only days before completing the questionnaire. 25 women (53.2%) had been with their abusive partners between 1 to 8 years on average. Only 8.5% were in a short-term relationship with the abuser lasting between one to six months. Twenty three percent of women were in a relationship with the abusive partner for 10 years or longer. Figures 4.2. and 4.3. further illustrate time since the abusive relationship as well as the length of abusive relationships. No differences between groups in this regard have been found.

Table 5

Marital Status of Participants

Marital Status	n	%
Single	21	41.2
Married	2	3.9
Separated	14	27.5
Divorced	9	17.6
Other	4	7.8
Missing	1	2.0
Total	51	100

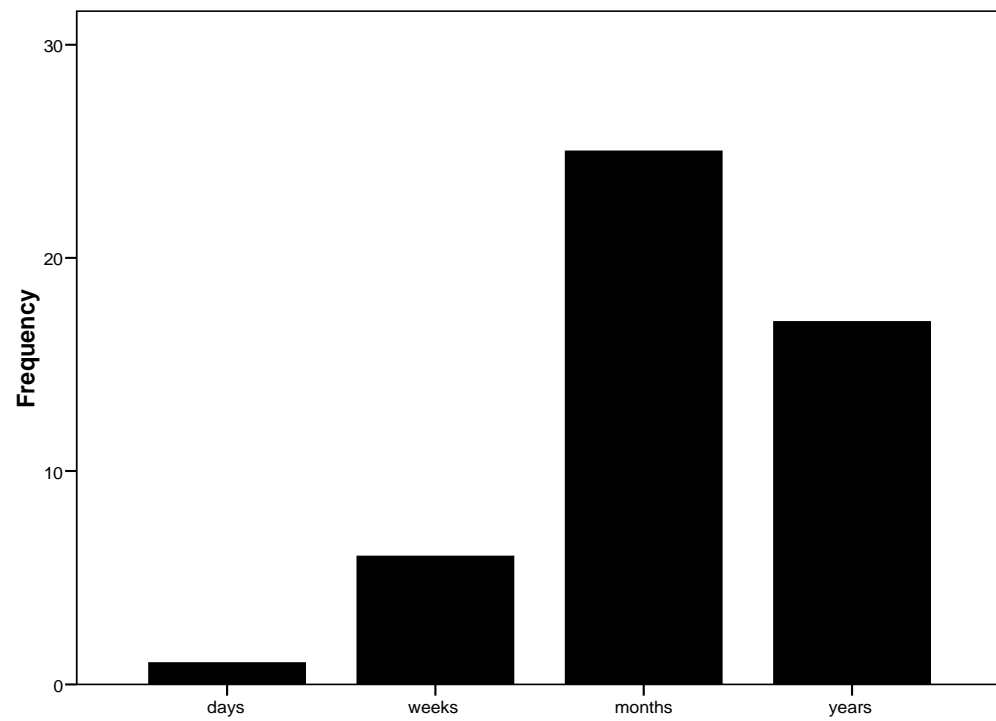


Figure 4.2. Time since leaving Abusers

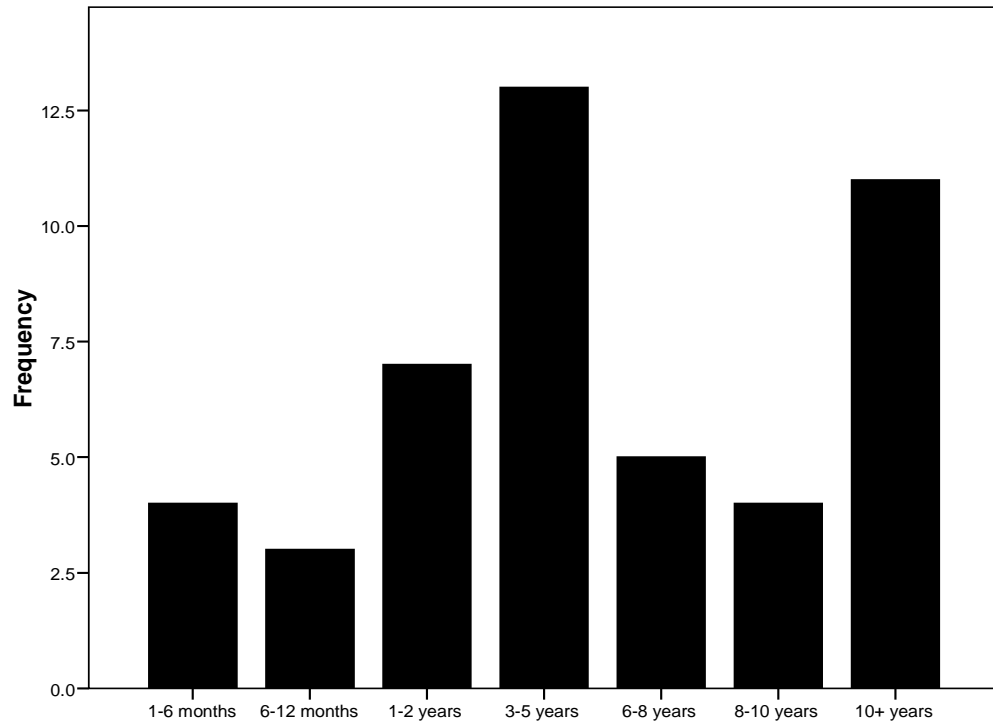


Figure 4.3. Length of Abusive Relationships

4.2.1.7. Previous therapy experience

In the sample, 39.2% of participants had prior therapy experience. Of those women, 11.8% had some form of therapeutic intervention (support groups or one-on-one therapy) from another source during the course of the study. 47.4% of women in the Art Therapy group had experienced therapy before, 10.2% (2 participants) of those were still in another therapeutic relationship at the time of the study. 42.9% of women in the control group have had therapy before, and two women (14.3%) were still in therapy at the onset of the study. Only 27.8% of women in the control group had any experience with therapy before and two women (11.1%) were in therapy at the time of their participation. There was no difference between the groups in terms of previous therapy experience. Because

of the small number of participants who attended additional therapy at the time baseline information was collected, the possible influence of simultaneous interventions has not been analysed. No interaction between previous therapy experience and the decision to take part (and remain) in the study has been found.

4.2.1.8. Socio-demographic variables and well-being

One way between-groups analyses of variance, t-tests and chi-square explorations were used to examine any effects of socio-demographic factors. Particular focus was placed on the effect of socio-economic variables on psychological well-being. The results show that occupation seems to have had an impact on depression, $t(44) = 2.124$, $p = .04$ (two tailed), $\eta^2 = .09$, and global severity of symptoms, $t(43) = 1.96$, $p = .06$, (two tailed), $\eta^2 = .08$, at baseline and on self-efficacy at T 2, $t(22.96) = 3.08$, $p = .005$, $\eta^2 = .24$. Non-manual workers tended to have higher perceived self-efficacy at T2 but seemed more depressed and reported marginally higher severity of symptoms at the onset of the study (T1).

4.2.2. Psychological Profile of Participants at Baseline

A multiple analysis of variance was conducted to find differences between groups on major outcome measures (self-efficacy, self-esteem, depression, and global severity) as well as symptoms of PTSD. A difference was only found for self-efficacy at baseline. There was statistically significant difference between the control group and other groups on self-efficacy, $F(2, 44) = 3.746$, $p = .032$, η^2 partial = .155). This finding was confirmed in a one-way between groups analysis of variance, $F(2, 47) = 3.47$, $p = .04$). Post hoc tests (Tukey) revealed a significant difference between the control group and the Person-Centred group on this

measure. Women in the Art Therapy group had a mean score of 25.72 on the GSE ($SD = 7.36$). Participants in the Person-Centred group had mean GSE score of 23.29 ($SD = 6.7$). Control group participants had a slightly higher mean GSE score of 29.06 ($SD = 4.33$). Women in the control group had significantly higher perceived self-efficacy than women in the Person-Centred group who began the therapy at the lowest level of self-efficacy. Means and standard deviations of all measures can also be found in table 6.

4.2.2.1. Self-efficacy

The mean score for self-efficacy was 26.24. Various levels of perceived self-efficacy were reported by participants ranging from 10 to 38. The highest score obtainable in this test is 40, the lowest 0. Self-efficacy scores were not normally distributed. In the exploration, both the Kolmogorov-Smirnov test as well as Levene's test indicated a non-normal distribution of scores. Kolmogorov-Smirnov ($p = .00$), Levene's test: $F(2, 47) = 4.80, p = .01$. In this sample the scores were somewhat skewed to the right indicating a rather high perception of self-efficacy.

4.2.2.1. Self-esteem

Self-esteem scores ranged from 0 (one participant) to 24 (also one participant). The mean score for self-esteem was 15.75. On the Rosenberg Self-esteem Scale (RSE), a score of 15 or below indicates considerably low self-esteem. Using this number as an indicator, almost half of the women in this study (47%) suffered from low self-esteem. Participants in the Art Therapy group had a mean score of 16.26 on the RSE with a standard deviation of 4.12, women in the Person-Centred group had a mean score of 13.36 with a standard deviation of 6.29 on that measure and women in the control group had a mean score of 17.17 with a

standard deviation of 3.13. This difference was not statistically significant ($p = .06$).

4.2.2.3. Depression

The mean score for the BDI-II was 24.7. Only 19% of participants suffered from no or mild depression, 15% suffered from mild depression, whereas 27% suffered moderate depression. A large number of participants (39%) reported symptoms of severe depression. On the BDI-II, women in the Art Therapy group scored in the higher ranges with a mean score of 27.59, standard deviation 8.58. Participants in the Person-Centred Therapy groups had a mean score of 26.21 with a standard deviation of 13.44 on the BDI-II, whereas participants in the control group had the lowest mean score of 21.29 with a standard deviation of 11.09. This difference was not statistically significant ($p = .23$).

4.2.2.4. General Psychological well-being

In this sample, 44.7% of women reported above normal levels on the clinical range (a T score of 65 or above) of somatic problems. 72.3% scored above normal on the obsessive compulsive subscale as well as on the interpersonal sensitivity and phobic anxiety subscales. 74.5% of participants reported clinical levels of depression and anxiety on this measure. 53.2% scored a T score of 65 or above on the *Hostility* subscale. 78.7% scored in the clinical range of the *Paranoid Ideation* subscale and 74.5% on the *Psychoticism* subscale. The mean raw score for the Global Severity Index was 1.62. In general, the majority of women in this sample report less psychological well-being than women in the general population using T-scores as an indicator. All subscales have been checked for differences at baseline (T1) there was no significant difference

between groups at T1 after Bonferoni corrected analyses of variance. See Appendix F for the corresponding table.

4.2.2.5. Coping Responses

Women in the present sample scored somewhat higher than normal on questions related to avoidance coping responses, but were in the normal ranges in regard to active/approach coping mechanisms. Participants were not highly dysfunctional or abnormal in their coping responses. The data in this study do not support the assumption that survivors of domestic violence do not use active coping strategies in their daily lives. Scores on all subscales were normally distributed. There were no significant differences between the groups on any subscale of the Coping Responses Inventory ($p > .20$).

4.2.2.6. Symptoms of Posttraumatic Stress Disorder (PTSD)

Women in the current sample had elevated scores on the subscales of *Intrusive Experiences* and *Defensive Avoidance*, when compared with T-scores. In regard to other main symptoms of PTSD, on the subscales of *Anxious Arousal* and *Anger/Irritability* 20.8% women reported clinical levels, 45.8% reported clinical ranges of *Depression*, 43.7% reported clinical levels of *Intrusive Experiences*, 43.7% reported clinical levels of *Defensive Avoidance* and 47.9% reported clinical ranges of dissociation. There were no differences between the three groups on any of the subscales of the TSI ($p > .12$)

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Table 6

Summarised Profile of Participants on Psychometric Measures

Measure	Entire Sample			Art Therapy	Person Centred Therapy	Control	p
	n	M	(SD)				
Self-efficacy	50	26.24	(6.54)	25.72 (7.36)	23.29 (6.70)	29.06 (4.33)	.04
Self-esteem	51	15.74	(4.71)	6.26 (4.12)	13.36 (6.29)	17.17 (3.13)	.06
Depression	48	24.96	(11.17)	27.59 (8.58)	26.21(13.4 4)	21.29(11.09)	.23
Psychological Well-being							
<i>Somatisation</i>	47	1.40	(0.88)	1.75 (0.95)	1.28 (0.83)	1.10 (0.73)	.08
<i>Obsessive</i>	47	1.87	(0.90)	2.17 (0.92)	1.65 (0.92)	1.70 (0.82)	.20
<i>Interpersonal Sensitivity</i>	47	1.81	(0.97)	2.02 (0.89)	1.83 (1.08)	1.56 (0.96)	.39
<i>Depression</i>	47	1.96	(0.89)	2.04 (0.83)	1.95 (1.00)	1.87 (0.90)	.86
<i>Anxiety</i>	47	1.54	(0.88)	1.75 (0.86)	1.37 (0.89)	1.44 (0.89)	.44
<i>Hostility</i>	47	1.21	(0.50)	1.63 (1.12)	0.79 (0.59)	1.07 (0.92)	.05
<i>Phobic Anxiety</i>	47	1.35	(1.01)	1.43 (0.97)	1.37 (1.14)	1.25 (0.99)	.88
<i>Paranoid Ideation</i>	47	1.83	(0.89)	2.13 (0.79)	1.73 (0.95)	1.56 (0.92)	.16
<i>Psychoticism</i>	47	1.29	(0.95)	1.52 (1.04)	0.99 (0.94)	1.27 (0.81)	.31
Global Severity Index		1.62	(0.75)	1.75 (.95)	1.28 (.83)	1.10 (.73)	.24
CRI Subscales							
<i>Logical Analysis</i>	46	8.74	(3.91)	8.47 (2.53)	9.14 (5.03)	8.65 (4.08)	.89
<i>Positive Reappraisal</i>	46	9.33	(4.11)	9.87 (3.70)	8.14 (4.49)	9.82 (4.17)	.44
<i>Seeking Guidance and Support</i>	46	8.65	(4.07)	10.00 (3.93)	8.71 (3.87)	7.41 (4.18)	.20
<i>Problem Solving</i>	46	9.65	(9.65)	9.73 (3.11)	9.64 (5.09)	9.59 (3.79)	.99
<i>Cognitive Avoidance</i>	46	11.50	(3.73)	11.67 (3.16)	11.57 (3.92)	11.29 (4.24)	.96
<i>Acceptance/Resignat ion</i>	46	10.13	(4.05)	10.33 (2.58)	11.29 (4.36)	9.00 (4.73)	.29
<i>Seeking Alt. Rewards</i>	46	6.59	(3.89)	6.93 (4.40)	5.50 (3.59)	7.18 (3.70)	.46
<i>Emotional</i>	46	7.89	(3.60)	8.33	7.43	8.12 (4.01)	.79

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<i>Discharge</i>				(3.64)	(3.20)		
Symptoms of PTSD							
<i>Anxious Arousal</i>	48	11.56	(4.75)	11.24 (5.14)	11.64 (4.89)	11.82 (4.50)	.94
<i>Depression</i>	48	13.85	(6.08)	14.53 (6.09)	14.50 (6.78)	12.65 (5.62)	.61
<i>Anger Irritability</i>	48	12.19	(6.31)	13.29 (6.50)	9.29 (5.95)	13.47 (5.95)	.12
<i>Intrusive Experiences</i>	48	13.92	(5.42)	12.88 (5.12)	13.57 (4.67)	15.24 (6.26)	.44
<i>Defensive Avoidance</i>	48	15.58	(4.44)	14.00 (4.23)	16.64 (4.13)	13.29 (4.70)	.19
<i>Dissociation</i>	48	11.38	(5.28)	11.47 (5.06)	11.43 (5.45)	11.24 (5.67)	.41
<i>Sexual Concerns</i>	47	5.72	(5.94)	6.06 (5.84)	4.00 (5.28)	6.82 (6.56)	.41
<i>Dysfunctional Sexual Behaviour</i>	48	4.06	(6.01)	3.88 (4.86)	1.93 (4.01)	6.00 (7.83)	.17
<i>Impaired Self-reference</i>	48	13.35	(6.08)	13.65 (5.98)	12.93 (6.99)	13.41 (5.73)	.95
<i>Tension Reduction Behaviour</i>	48	5.35	(4.16)	5.88 (3.72)	3.71 (2.89)	6.18 (5.17)	.21

Note. Means (and Standard Deviations) of all dependent variables, the entire sample and individual groups

4.2.3. Results of the Main Analyses

Several measures were used to assess psychological well-being at those three times of assessment. As indicated previously, not all scores were normally distributed throughout the study. When assumptions for multivariate testing were violated, but others were given (homogeneity, homoscedasticity, etc.) the appropriate normalisation procedures were applied (log transformations, square root transformations). Where normalisation could not be achieved, non-parametric alternatives (e.g. Friedman's test) were chosen to measure change in one variable over the three time points. An indication of effect sizes for Friedman's tests will be represented by r , which was calculated from Wilcoxon signed-rank test (Field, 2005).

Because of the significant drop-out of participants between data collection T2 and T3, a separate analysis was conducted additionally to investigate the short

term effects of either intervention. For this analysis, baseline data (T1) were compared to data collected shortly after the intervention (T2) therefore only pre- and post-intervention data are compared. A series of 2 x 3 mixed subjects analysis of variance were conducted to for this exploration. The results of the analyses are outlined in detail below.

4.2.3.1. General Self Efficacy

General self-efficacy was measured using the General Self-Efficacy Scale (GSE). In order to examine the differential effects of the three interventions on the perceived self-efficacy of participants over all three points in time a 3 x 3 mixed subjects analysis of variance was conducted. There was a statistically significant large main effect of time $F(2, 40) = 4.50, p = .02, \eta^2 \text{ partial} = .18$. Simple contrasts revealed that self-efficacy at T2, but not T3, was significantly higher than at T 1 $F[1, 20] = 9.42, p < .01$. The means are presented in table 7. There was also a significant, large, interaction effect between therapy group and time of data collection $F(4, 40) = 3.23, p = .02, \eta^2 \text{ partial} = .24$. Figure 5.4. illustrates the interaction, indicating that there are larger differences in self-efficacy across the three time points for the art therapy group than for the other two therapy groups. Simple effect analysis reveals that the effect is significant in the art therapy group, and not significant in the other groups. Simple contrasts show that at both post-treatment time points self efficacy was significantly higher than at baseline (both $F_s < 7.00$, both $ps < .04$). The main effect for group did not reach statistical significance $F(2, 20) = .62, p = .55, \eta^2 \text{ partial} = .06$.

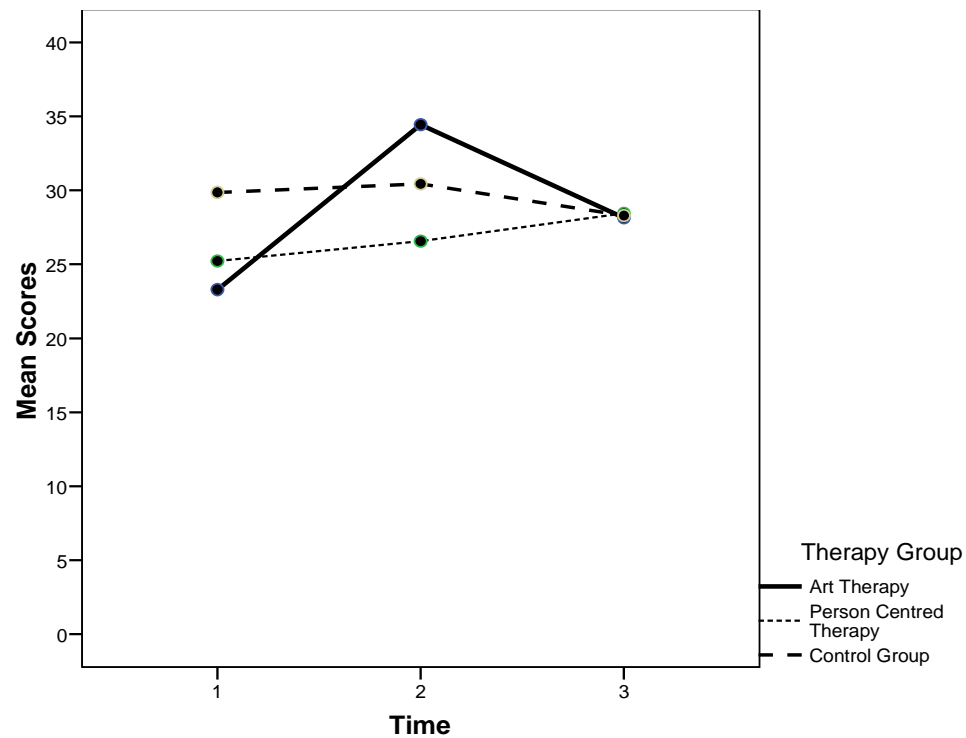


Figure 4.4. Profile Plot for General Self-Efficacy

Because significant differences between groups on this measure were found at baseline, an additional three factor analysis of covariance was conducted, controlling for self-efficacy at baseline. The dependent variable was self-efficacy at T3. After adjusting for self-efficacy at T1 there was no significant group effect $F(2, 23) = .906, p = .42, \eta^2 \text{ partial } .09$.

Violation of assumptions

As indicated above, the scores of the GSE were not normally distributed at any point of measurement. Both the Levene's test as well as the Kolmogorov-Smirnov test indicate a violation of assumptions of ANOVA. Transformations had no effect on the distribution of the data hence a non-parametric alternative

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(Friedman's test) was chosen additionally to explore changes in general self-efficacy scores over time.

General Self-efficacy, Friedman's test

In the Art Therapy condition, the measure of self efficacy changed significantly over the three time periods, $\chi^2(2) = 11.31, p = .004$. Wilcoxon tests were used for post hoc exploration. A Bonferroni correction was applied and effects are reported at a .0167 level of significance. The measure of self efficacy changed significantly from T1 to T2 $T = 3, r = -.46, (p = .012)$. The measure did not change significantly however from T1 to follow up T3, $T = .00, r = -.44, (p = .027)$ and from T2 to T3, $T = 1.50, r = -.45, (p = .058)$. The measure of self-efficacy did not change significantly over the three time periods in the Person-Centred condition, $\chi^2(2) = .22, p = .895 (p > .05)$, or the control condition, $\chi^2(2) = .274, p = .25 (p > .05)$.

Short-term effects

There was a significant effect for time $F(1, 30) = 8.31, p = .01, \eta^2 \text{ partial} = .22$ and for group $F(2, 30) = 4.17, p = .03, \eta^2 \text{ partial} = .22$. Participant's scores on the measure of self-efficacy increased significantly during the time of the intervention. Post hoc comparisons (Tukey HSD) revealed a significant difference between the control group and the Person-Centred group (mean difference = +/- 6.04). The interaction effect was also significant $F(2, 30) = 4.19, p = .025, \eta^2 \text{ partial} = .22$. Simple effect analysis reveals that the effect is significant in the Art Therapy group, and not significant in the other groups. Simple contrasts show that

at the follow up measurement self efficacy was significantly higher than at baseline for this group.

4.2.3.2. Self-Esteem

Self-esteem was measured using the Rosenberg Self-esteem Scale (RSE).

In order to examine the differential effects of the three interventions on self-esteem of participants over all three point in time a 3 x 3 mixed subjects analysis of variance was conducted. The assumption of sphericity has been violated, therefore multivariate test statistics have been used in the report of ANOVA results regarding the measure of self-esteem. There was a statistically significant main effect for time $F(2, 19) = 4.31, p = .03 \eta^2 \text{ partial} = .32$). Simple contrasts revealed that self-efficacy at T 2, as well as at T 3, was significantly higher than at T 1 $F(1, 19) = 7.68, p < .05$ and $F(1, 19) = 8.38, p < .05$. The means are presented in table 7 below. There was also a significant, large, interaction effect between therapy group and time of data collection $F(2, 19) = 3.57, p = .02, \eta^2 \text{ partial} = .28$. Figure 4.5. further illustrates the interaction and the differences in self-esteem across the three time points. Simple effect analysis reveals that the effect is significant in the Art Therapy condition between T 1 and T 2. In the Person-centred condition, the effect is significant between T 2 and T 3. There is no significant change in the measure of self-esteem in the control condition. The main effect for group did not reach statistical significance $F(2,19) = .57, p = .58, \eta^2 \text{ partial} = .06$.

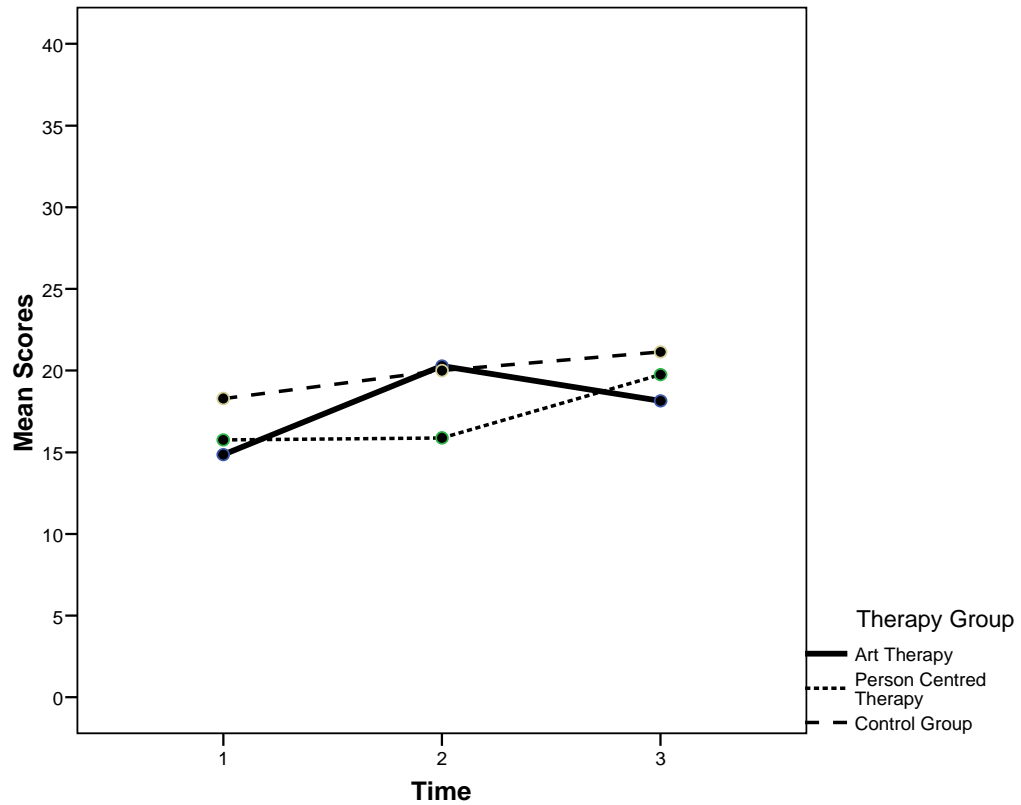


Figure 4.5. Profile Plot for Self-Esteem

Short-term effects

There was a significant effect for time, $F(1, 30) = 13.11, p = .001, \eta^2 \text{ partial} = .30$.

Participant's scores on the measure of self-esteem had increased significantly shortly after the intervention. The main effect for group did not reach statistical significance, $F(2, 30) = 3.08, p = .06, \eta^2 \text{ partial} = .17$. The interaction effect was significant, $F(2, 30) = 3.22, p = .05, \eta^2 \text{ partial} = .18$. Simple effect analysis reveals that the effect is significant in the Art Therapy group, $F(1, 9) = 8.73, p = .02, \eta^2 \text{ partial} = .49$, and marginally significant in the control group $F(1, 12) = 5.03, p = .05, \eta^2 \text{ partial} = .29$. Simple contrasts show that at the follow up measurement self esteem was significantly higher than at baseline for women in these two groups.

4.2.3.3. Depression

The Beck Depression Inventory II (BDI-II) was used to assess symptoms of depression. In order to examine the differential effects of the three interventions participants' depression over all three point in time a 3 x 3 mixed subjects analysis of variance was conducted. There was a statistically significant large main effect of time $F(2, 30) = 13.42, p = .00, \eta^2 \text{ partial} = .47$. Simple contrasts revealed that depression at T 2, as well as at T 3, was significantly higher than at T 1, $F(1, 15) = 28.07, p < .01$ and $F(1, 15) = 19.38, p < .01$. The means are presented in table 7. There was also a significant, large, interaction effect between therapy group and time of data collection, $F(4, 30) = 13.34, p = .00, \eta^2 \text{ partial} = .64, \text{Power} = 1.00$. Figure 4.6. illustrates the interaction, indicating that there are larger differences in depression across the three time points for the Art Therapy group and the Person-Centred group. Simple contrasts show that women in the Art Therapy condition score much lower on the BDI-II at T 2 and T 3 than at T 1. There is also a large difference for women in the Person-Centred group, however depression scores increase at T 2 but significantly decrease at T 3. Simple effect analysis reveals that the effect is significant in the Art Therapy group (T 2 and T 3 significantly higher than T 1, T 3 is also significantly different from T 2) and for the Person-centred group (T 2 is marginally significantly different from T 1, i.e. scores increase, but scores at time 3 are significantly different from baseline scores, i.e. depression decreased significantly). There are no significant differences in depression for women in the control group. The main effect for group did not reach statistical significance $F(2, 15) = .20, p = .83$. The effect size was very small however ($\eta^2 \text{ partial} = .03$) and the lack of power could have contributed to the non-significant result in this case.

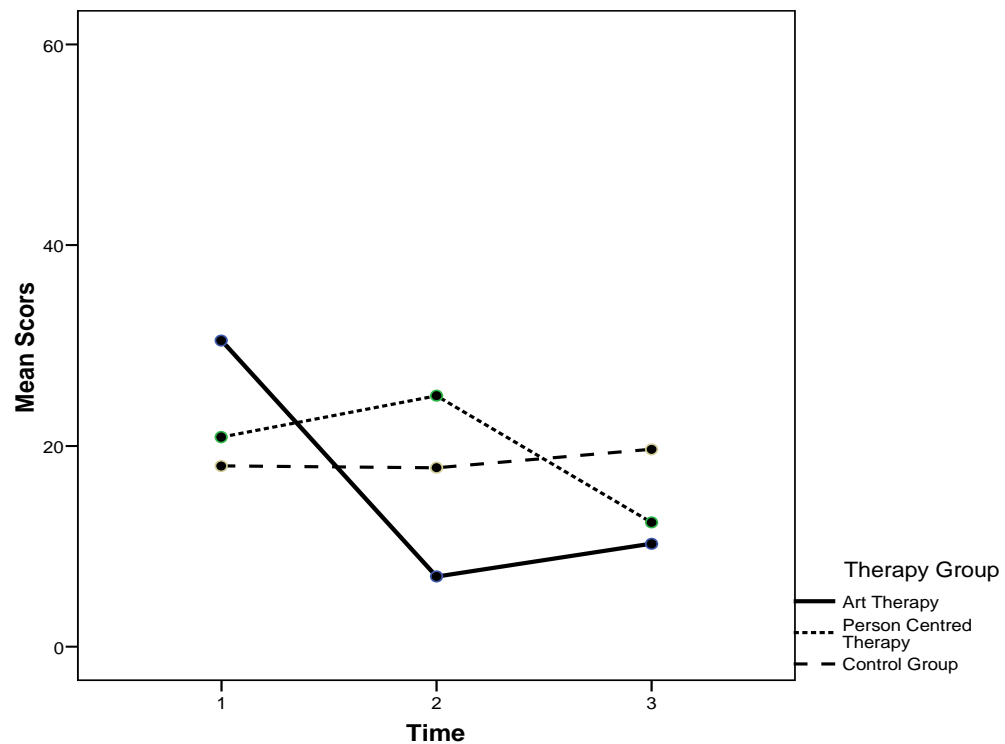


Figure 4.6. Profile Plot for Depression

Short-term Effects

There was a significant effect for time, $F(1, 28) = 40.18, p = .00, \eta^2 \text{ partial} = .59$. Scores in the Beck Depression Inventory II significantly decreased overall for participants between T 1 and T 2 of data collection. The interaction effect was significant, $F(2, 28) = 26.58, p = .00, \eta^2 \text{ partial} = .66$. Simple effect analysis reveals that the effect is significant in the Art Therapy group, $F(1, 7) = 69.81, p = .00, \eta^2 \text{ partial} = .91$, and not in the other two groups. Simple contrasts show that at the follow up measurement T 2, depression was significantly lower than at baseline for women in this group. The main effect for group was not significant $F(2, 28) = 2.73, p = .08, \eta^2 \text{ partial} = .16$.

Table 7

Differences in means across different points in time for Self-efficacy, Self-esteem and Depression

Scale	T1	T2	T3	p
Self-efficacy, GSE	25.85	30.37	28.29	.02*
Self-esteem, RSE	16.27	18.58	19.68	.03*
Depression, BDI II	22.06	18.61	14.33	.00**

Note. * $p < .05$, ** $p < .01$

4.2.3.4. General Psychological Well-being

General psychological well-being has been measured by the Symptom Checklist (SCL-90-R). A 3 x 3 mixed subjects analysis of variance was conducted to explore the effects of the different interventions on psychological well-being over time. The global severity index was used as an overall indicator for the severity of the general psychological distress of participants. This score was used in all three measurements as the main indicator. However, in order to gain a more complete and detailed picture of the effect of an intervention, all subscales indicating psychopathology have also been included in the analysis. Only two of the nine subscales (*Depression* and *Paranoid Ideation*) were normally distributed throughout the investigation. The remaining subscale-scores were skewed and a non-parametric alternative (Friedmans's test) was chosen in addition to raw data. Two subscales (*Hostility* and *Psychoticism*) were not normally distributed throughout all three time points and have been transformed using log transformation and square root transformation respectively. In this case, transformed data have been used in the analysis. The results of analyses of the various subscales are presented below.

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SCL-90-R Overall score: Global Severity Index

There was a statistically significant large main effect of time, $F(2, 36) = 25.15, p = .00, \eta^2 \text{ partial} = .58$). Simple contrasts revealed that the global severity index at T 2 and at T 3 were significantly lower than at T 1, $F(1, 18) = 28.92, p < .01$ and $F(1, 18) = 34.72, p < .01$. The means are presented in table 8. There was also a significant, interaction effect between therapy group and time of data collection, $F(4, 36) = 11.56, p = .00, \eta^2 \text{ partial} = .56$. Figure 4.7. illustrates the interaction, indicating that there is a larger differences in global severity index scores for the Art Therapy group. Simple effect analysis reveals that the effect is significant only in the Art Therapy condition but not in the other conditions. Simple contrasts show that in the Art Therapy condition global severity at T 2 and T 3 was significantly lower than at T 1. The main effect for group did not reach statistical significance $F(2, 18) = .18, p = .84, \eta^2 \text{ partial} = .02$.

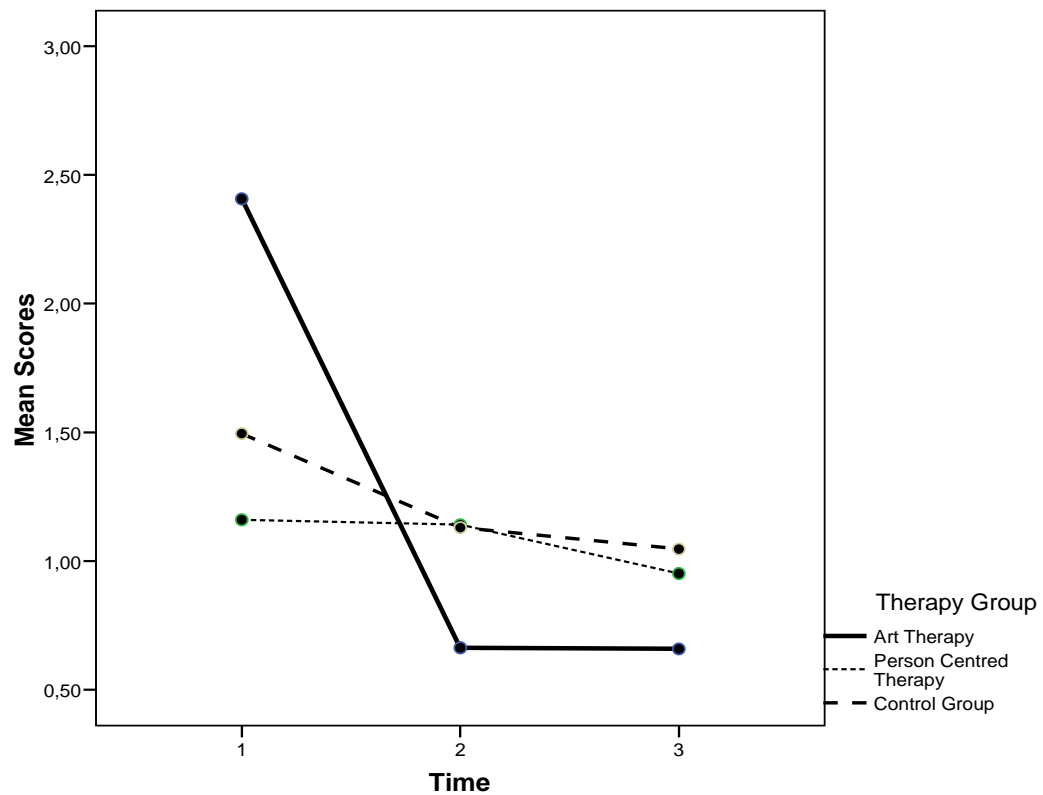


Figure 4.7. Profile Plot for Global Severity

Global Severity Index, Short-term Effects

There was a significant effect for time, $F(1, 28) = 19.63, p = .00, \eta^2 \text{ partial} = .41$. Scores on the overall score of global (symptom) severity significantly decreased overall for participants between T 1 and T 2 of data collection. The interaction effect was also significant, $F(2, 28) = 8.57, p = .00, \eta^2 \text{ partial} = .38$. Simple effect analysis reveals that the effect is significant in the Art Therapy group, $F(1, 9) = 15.20, p = .00, \eta^2 \text{ partial} = .63$, but not in the other two groups. Simple contrasts show that at the follow up measurement T 2, global severity scores were significantly lower than at baseline for women in the Art Therapy group. The main effect for time did not reach statistical significance, $F(2, 28) = 1.66, p = .21, \eta^2 \text{ partial} = .11$.

Subscale *Somatisation*

There was a statistically significant large main effect of time, $F(2, 36) = 15.52, p = .00, \eta^2 \text{ partial} = .46$. Simple contrasts revealed that scores on the subscale *Somatisation* at T2 and T3, was significantly higher than at T1, $F(1, 18) = 21.19, p < .01$ and $F(1, 18) = 17.29, p < .01$. The means are presented in table 8 below.

There was also a significant, large, interaction effect between therapy group and time of data collection, $F(4, 36) = 10.31, p = .00, \eta^2 \text{ partial} = .53$). Figure 4.8 illustrates the interaction, indicating that there are larger differences in *Somatisation* scores across the three time points for the Art Therapy group than for the other two therapy groups. Simple effect analysis reveals that the effect is significant in the Art Therapy condition, and not significant in the other conditions. Simple contrasts show that at both post-treatment time points *Somatisation* scores were significantly lower than at baseline for women who participated in Art Therapy. The main effect for group did not reach statistical significance $F(2, 18) = 1.49, p = .25, \eta^2 \text{ partial} = .14$.

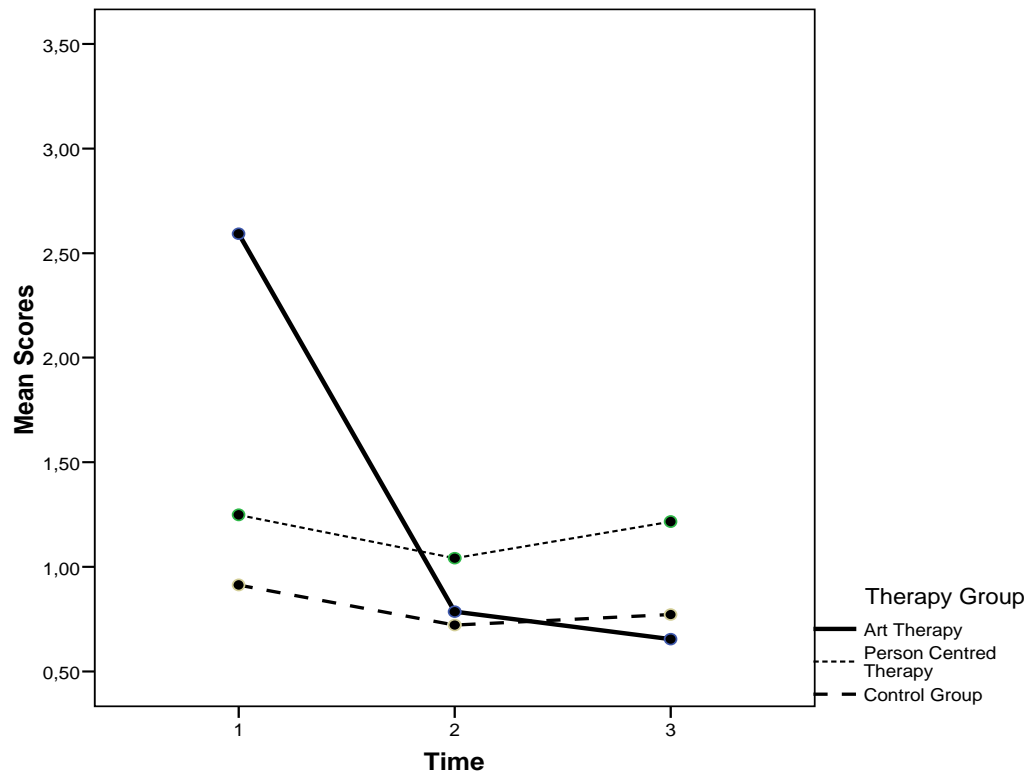


Figure 4.8. Profile Plot for Somatisation

Subscale *Somatisation*, Friedman's test

In the Art Therapy condition, the SCL-90-R measure of somatisation changed significantly over the three time periods, $\chi^2(2) = 11.19, p = .004$ ($p < .05$). Wilcoxon tests were used for post hoc exploration. A Bonferroni correction was applied and effects are reported at a .0167 level of significance. The measure of somatisation did not change significantly from T 1 to T 2, $T = 7, r = -.39, (p = .04)$. The measure changed marginally significantly however from T1 to T 3, $T = .00, r = -.47, (p = .02)$ but not significantly from T 2 to T, $T = 7, r = -.17, (p = .46)$. The SCL-90-R measure of somatisation did not change significantly over the three time periods in the Person-Centred condition, $\chi^2(2) = .25, p = .88$ ($p > .05$), or the control condition $\chi^2(2) = .26, p = .88$ ($p > .05$).

Short-term Effects

There was a significant effect for time, $F(1, 28) = 8.04, p = .01, \eta^2 \text{ partial} = .22$. Scores on this subscale significantly decreased overall for participants between T 1 and T 2 of data collection. The interaction effect was also significant, $F(2, 28) = 4.46, p = .021, \eta^2 \text{ partial} = .24$. Simple effect analysis reveals that the effect is significant in the Art Therapy group, $F(1, 9) = 7.56, p = .02, \eta^2 \text{ partial} = .46$, and not in the other two groups. Simple contrasts show that at the follow up measurement T 2, *Somatisation* scores were significantly lower than at T 1 for women in this group. The main effect for group was not significant, $F(2, 28) = 2.94, p = .07, \eta^2 \text{ partial} = .17$.

Subscale *Obsessive-Compulsive*

The assumption of sphericity has been violated in this analysis, therefore multivariate statistics have been chosen in the report of results. There was a statistically significant main effect for time, $F(2, 18) = 8.13, p = .003$ with a very large effect size $\eta^2 \text{ partial} = .49$. Simple contrasts revealed that scores on the subscale “obsessive compulsive” at T 3, but not at T 2, was significantly higher than at T 1, $F(1,18) = 16.10, p < .01$. The means are presented in table 8 below. The interaction effect was also significant, $F(2,18) = 2.88, p = .04$, with a large effect size $\eta^2 \text{ partial} = .25$. The main effect for group did not reach statistical significance, $F(2, 18) = .77, p = .48$, moderate effect, $\eta^2 \text{ partial} = .08$]. Figure 4.9. illustrates the interaction, indicating that there are larger differences in *Obsessive-Compulsive* scores across the three time points for the Art Therapy group than for the other two therapy groups. At T 2, scores on this subscale increase before

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decreasing again at T 3. Simple effect analysis reveals that the effect is significant in the Art Therapy condition (between T1 and T 3), and not significant in the other conditions. Simple contrasts show that at the follow-up measurement *Obsessive-Compulsive* scores were significantly lower than at baseline for women who participated in Art Therapy.

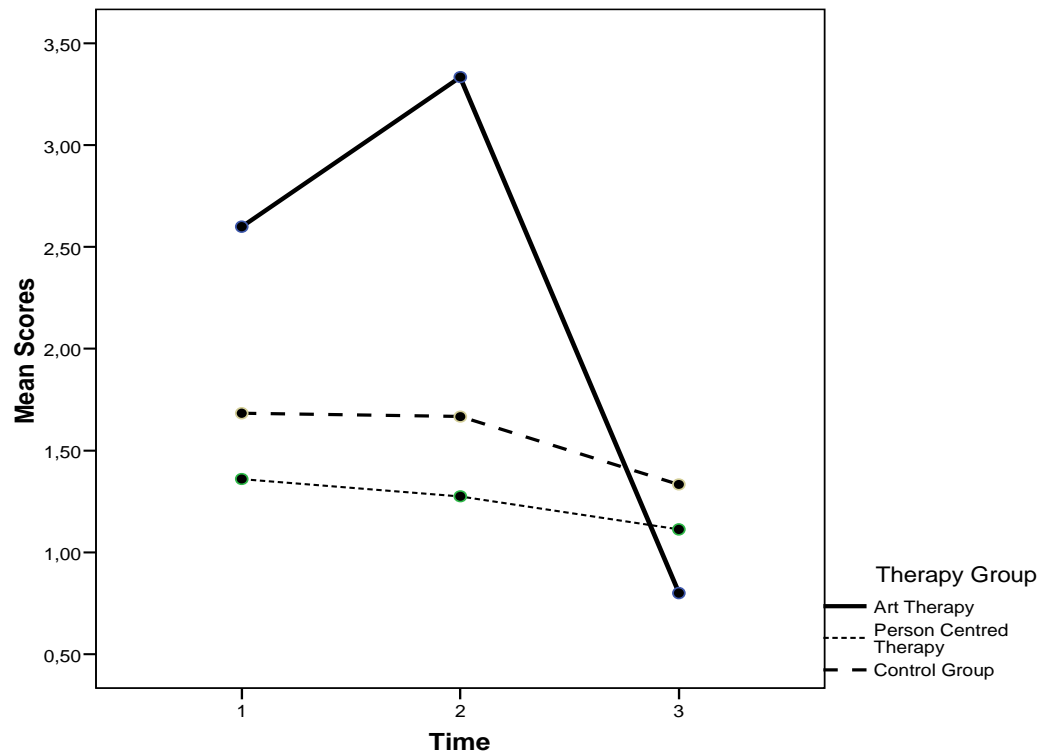


Figure 4.9. Profile Plot for Obsessive-Compulsive

Subscale Obsessive-compulsive, Friedman's test

In the Art Therapy condition, the SCL-90-R measure *Obsessive-Compulsive* changed significantly over the three time periods ($\chi^2(2) = 7.71, p = .02$ ($p < .05$)). Wilcoxon tests were used for post hoc exploration. A Bonferroni correction was applied and effects are reported at a .0167 level of significance. The measure of self efficacy did not change significantly from baseline to T 2, $T =$

9, $r = -.297$, ($p = .11$). The measure changed marginally significantly however from T 1 to T 3, $T = .00$, $r = -.47$, ($p = .018$), but not significantly from T 2 to T 3, $T = 13.50$, $r = -.02$, ($p = .18$). The SCL-90-R measure *Obsessive Compulsive* did not change significantly over the three time periods in the Person-Centred group, $\chi^2(2) = .84$, $p = .66$ ($p > .05$), and the control condition, $\chi^2(2) = 1.83$, $p = .40$ ($p > .05$).

Short-term Effects

There were no significant main effects for time, $F(1, 28) = .00$, $p = .99$, η^2 partial = .00, or group $F(2, 28) = 1.28$, $p = .29$, η^2 partial = .08. The interaction effect did also not reach statistical significance, $F(2, 28) = .13$, $p = .88$, η^2 partial = .01. The results indicate that there was no difference between T 1 and T 2 of data collection on the scores of the *Obsessive-Compulsive* subscale of the SCL-90-R. Effect sizes and resulting power were very small however, and a detection of a significant difference would have been unlikely.

Subscale *Interpersonal Sensitivity*

There was a statistically significant main effect for time, $F(2, 36) = 18.17$, $p = .00$, η^2 partial = .50. Simple contrasts revealed that scores on the subscale *Interpersonal Sensitivity* at T 3 and at T 2, was significantly higher than at T 1, $F(1, 18) = 30.55$, $p < .01$ and $F(1, 18) = 20.35$, $p < .01$. The means are presented in table 8 below. The interaction effect was also significant, $F(4, 36) = 5.96$, $p = .00$, η^2 partial = .40. The main effect for group did not reach statistical significance $F(2, 18) = .20$, $p = .82$, η^2 partial = .02]. Figure 4.10. illustrates the interaction, indicating that there are larger differences in interpersonal sensitivity

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scores across the three time points for the Art Therapy group than for the other two therapy groups. Simple effect analysis reveals that the effect is significant in the Art Therapy condition, and not significant in the other conditions. Simple contrasts show that at both post-treatment time points interpersonal sensitivity scores were significantly lower than at baseline for women who participated in Art Therapy.

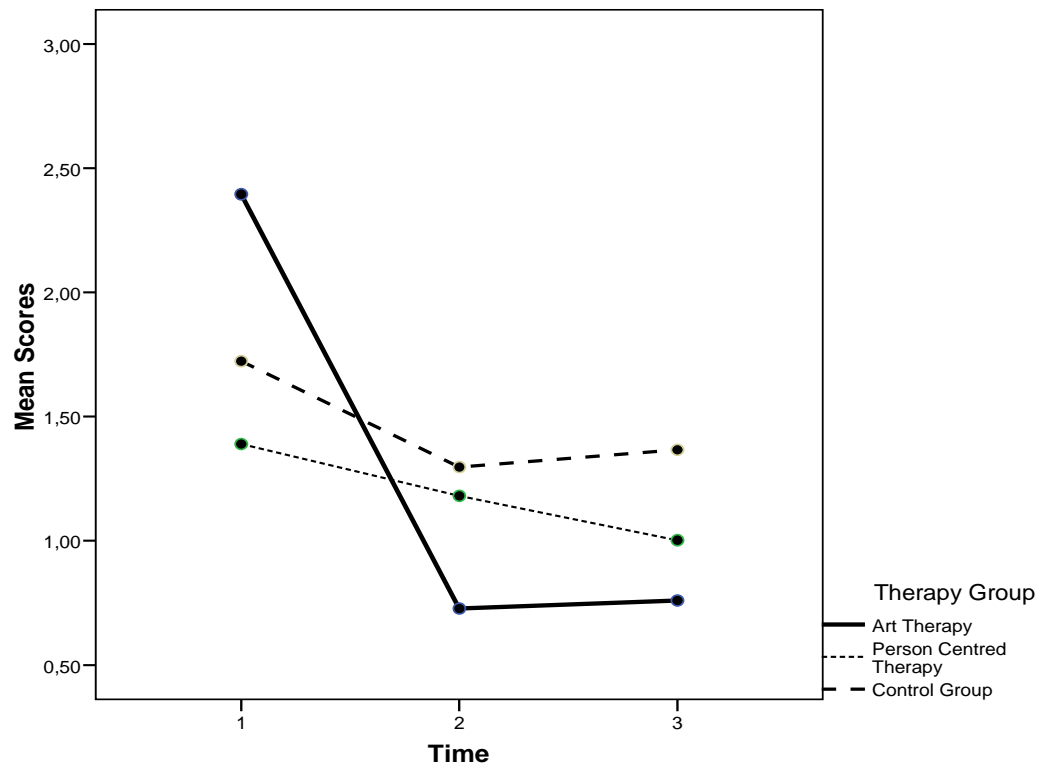


Figure 4.10. Profile Plot for Interpersonal Sensitivity

Subscale Interpersonal Sensitivity, Friedman's test

In the Art Therapy condition, the SCL-90-R measure of *Interpersonal Sensitivity* changed significantly over the three time periods $\chi^2(2) = 11.19, p = .004$ ($p < .05$). Wilcoxon tests were used for post hoc exploration. A Bonferroni correction was applied and effects are reported at a .0167 level of significance.

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The measure of interpersonal sensitivity changed significantly from T 1 to T 2, $T = .00$, $r = -.52$, ($p = .005$). The measure also changed from T 1 to T 3, $T = .00$, $r = -.47$, ($p = .02$) but not significantly from T2 to T 3, $T = 9$, $r = -.07$, ($p = .75$). In the Person-centred Therapy condition, The SCL-90-R measure *Interpersonal Sensitivity* did not change significantly over the three time periods in the Person-Centred condition $\chi^2(2) = 1.73$, $p = .42$ ($p > .05$) or the control condition $\chi^2(2) = 1.83$, $p = .40$ ($p > .05$).

Short-term Effects

There was a significant main effect for time, $F(1, 28) = 24.60$, $p = .00$, η^2 partial = .47. Scores on this subscale significantly decreased overall for participants between T1 and T2 of data collection. The interaction effect was also significant $F(2, 28) = 6.93$, $p = .004$, η^2 partial = .33. Simple effect analysis reveals that the effect is significant in the Art Therapy group, $F(1, 9) = 19.41$, $p = .00$, η^2 partial = .68, and the Person-centred group $F(1, 9) = 5.53$, $p = .04$, η^2 partial = .38, but not in the control group. Simple contrasts show that at the follow up measurement T 2, *Interpersonal Sensitivity* scores were significantly lower than at baseline for women in the intervention groups. The main effect for group did not reach statistical significance, $F(2, 28) = 1.58$, $p = .22$, η^2 partial = .10.

Subscale Depression

There was a statistically significant main effect for time, $F(2, 36) = 13.37$, $p = .00$, η^2 partial = .43. There was also a significant interaction effect between therapy group and time of data collection $F(4, 36) = 6.64$, $p = .00$, η^2 partial = .42. The main effect for group did not reach statistical significance $F(2, 18) = .23$, p

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η^2 partial = .03). Simple contrasts revealed that depression at T 2 and T 3, was significantly different than at T 1, $F(1, 18) = 19.97, p < .01$ and $F(1, 18) = 23.12, p < .01$. The means are presented in table 8 below. Figure 4.11. illustrates the interaction, indicating that there are larger differences in depression across the three time points for the Art Therapy group than for the other two therapy groups. Simple effect analysis reveals that the effect is significant in the Art Therapy group, and not significant in the other groups. Simple contrasts show that at both post-treatment measurement points depression was significantly lower than at baseline (both F s < 7.00 , both p s $< .04$).

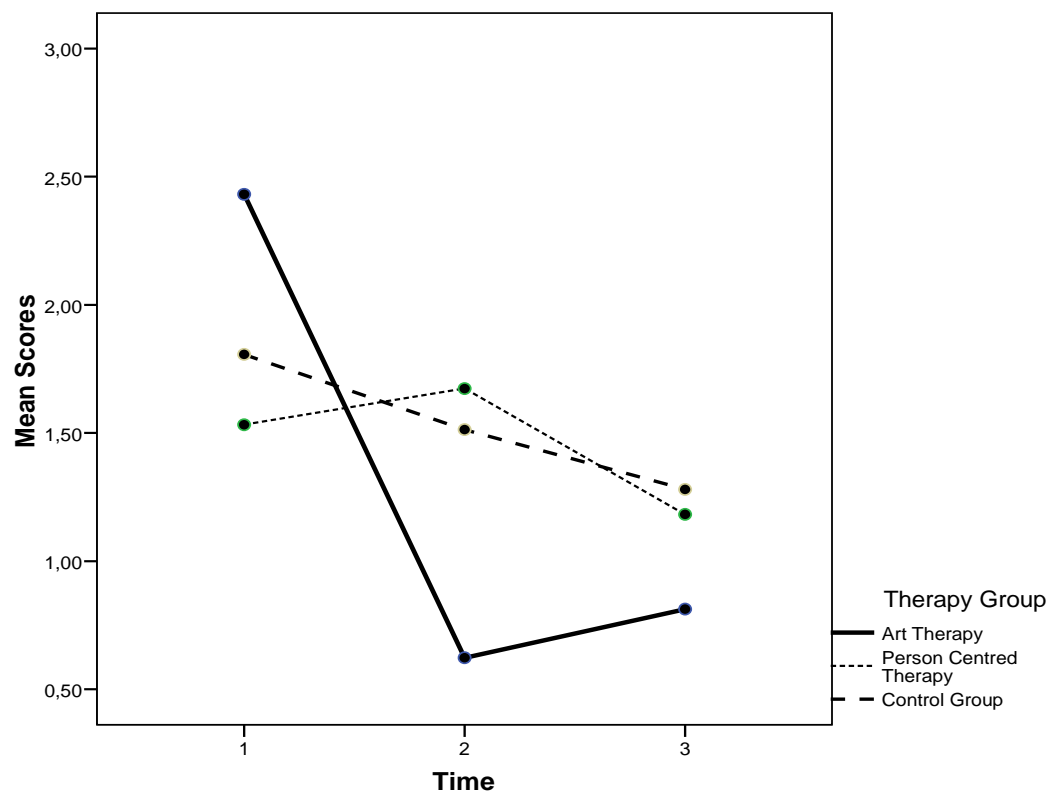


Figure 4.11. Profile Plot for Depression

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Short-term Effects

There was a large significant effect for time, $F(1, 28) = 23.93, p = .00, \eta^2$ partial = .46. Scores on this subscale significantly decreased overall for participants between T1 and T2 of data collection. The interaction effect was also significant, $F(2, 28) = 13.69, p = .00, \eta^2$ partial = .49. Simple effect analysis reveals that the effect is significant in the Art Therapy group $F(1, 9) = 32.24, p = .00, \eta^2$ partial = .78, but not in the other two groups. Simple contrasts show that at the follow up measurement T 2, depression scores were significantly lower than at baseline for women in the Art Therapy group. The main effect for group did not reach statistical significance, $F(2, 28) = 1.35, p = .26, \eta^2$ partial = .09.

Subscale Anxiety

There was a statistically significant main effect for time $F(2, 36) = 19.34, p = .00, \eta^2$ partial = .52. There was also a significant interaction effect between therapy group and time of data collection, $F(4, 36) = 7.64, p = .00, \eta^2$ partial = .46. Simple contrasts revealed that anxiety at T 2 and T 3, was significantly different than at T 1, $F(1, 18) = 25.80, p < .01$ and $F(1, 18) = 23.14, p < .01$. The means are presented in table 8 below. Figure 4.12. illustrates the interaction, indicating that there are larger differences in anxiety across the three time points for the Art Therapy group than for the other two therapy groups. Simple effect analysis reveals that the effect is significant in the Art Therapy group particularly between T 1 and T 2. Simple contrasts show that at both post-treatment measurement points depression was significantly lower than at baseline. The effect is also significant for the control group between T 1 and T 3, indicating that anxiety gradually decreased for women in the control condition during the five months of

contact. There was no significant change of scores for women who received Person-Centred Therapy. The main effect for group did not reach statistical significance, $F(2, 18) = .23, p = .80$, small effect size, η^2 partial = .03.

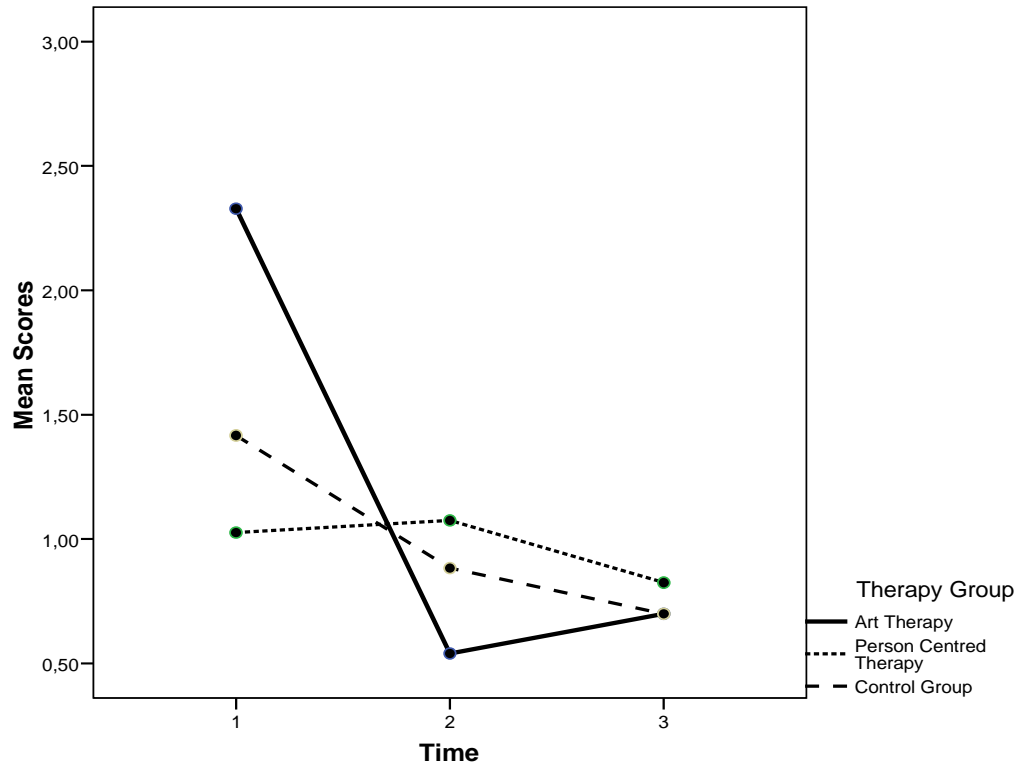


Figure 4.12. Profile Plot for Anxiety

Subscale *Anxiety*, Friedman's test

In the Art Therapy condition, the SCL-90-R measure of *Anxiety* changed significantly over the three time periods $\chi^2(2) = 12.08, p = .002 (p < .05)$.

Wilcoxon tests were used for post hoc exploration. A Bonferroni correction was applied and effects are reported at a .0167 level of significance. The measure of anxiety changed significantly from T 1 to T 2, $T = 1, r = -.50, (p = .007)$. The measure also changed marginally from T 1 to T 3, $T = .00, r = -.47, (p = .018)$ but not significantly from T 2 to T 3, $T = 2.50, r = -.22, (p = .36)$. The SCL-90-R

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measure *Anxiety* did not change significantly over the three time periods in the Person-Centred condition, $\chi^2(2) = 1.36, p = .51 (p > .05)$ and in the control condition, $\chi^2(2) = 5.33, p = .07 (p > .05)$.

Short-term Effects

There was a significant main effect for time, $F(1, 28) = 17.62, p = .00, \eta^2$ partial = .40. The interaction effect was significant $F(2, 28) = 8.67, p = .00, \eta^2$ partial = .38. Simple effect analysis reveals that the effect is significant in the Art Therapy group $F(1, 9) = 14.91, p = .00, \eta^2$ partial = .62, and not in the other two groups. Simple contrasts show that at the follow up measurement T2, *Anxiety* scores were significantly lower than at baseline for women in this group. The main effect for group did not reach statistical significance $F(2, 28) = 1.78, p = .19, \eta^2$ partial = .11.

Subscale *Hostility*

Scores of the SCL-90-R subscale hostility were not normally distributed throughout the study and transformed scores were used in the analysis.

There was a statistically significant main effect for time, $F(2, 24) = 7.42, p = .00, \eta^2$ partial = .38. Simple contrasts revealed that scores on the subscale *Hostility* at T 3, but not at T 2, was significantly lower than at T 1, $F(1, 18) = 35.32, p < .01$.

The means are presented in table 8 below. The interaction effect was also significant $F(4, 24) = 15.82, p = .00, \eta^2$ partial = .64. The main effect for group did not reach statistical significance $F(2, 12) = 1.59, p = .24, \eta^2$ partial = .21.

Figure 4.13. illustrates the interaction, indicating that there are larger differences in hostility scores across the three time points for the Art Therapy group and the

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control group. Simple effect analysis reveals that the effect is significant in the Art Therapy and control condition but not in the Person-Centred Therapy condition.

Simple contrasts show that at both post-treatment time points hostility scores were significantly lower at both post-treatment follow up measurements than at baseline for women who participated in Art Therapy. Simple contrasts show that at T3 *Hostility* scores were significantly lower than at T1 for the control condition, indicating a gradual decrease in hostility in that group.

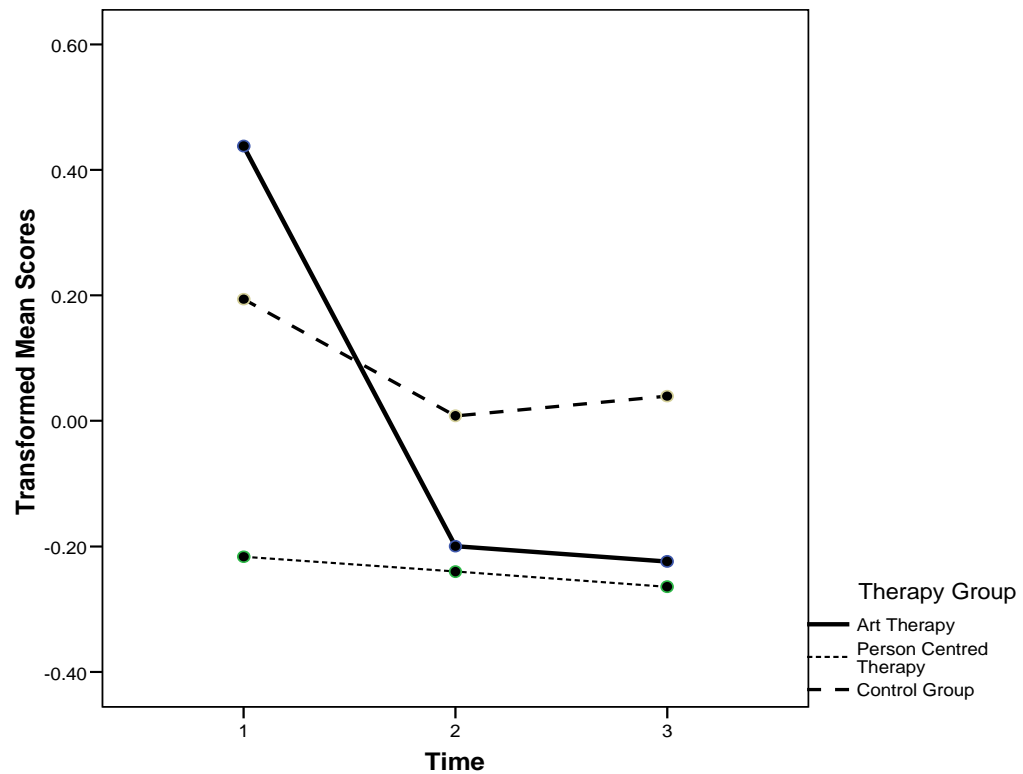


Figure 4.13. Profile Plot for Hostility

Subscale *Hostility*, Friedman's test

In the Art Therapy condition, the SCL-90-R measure of *Hostility* changed significantly over the three time periods, $\chi^2(2) = 10.57, p = .005 (p < .05)$.

Wilcoxon tests were used for post hoc exploration. A Bonferroni correction was

applied and effects are reported at a .0167 level of significance. The measure of hostility did not change significantly from T 1 to T 2, $T = 10$, $r = -.41$, ($p = .07$). However, hostility changed marginally from T 1 to T 3, $T = .00$, $r = -.47$, ($p = .018$) but not significantly from T 2 to T 3, $T = 13$, $r = -.04$, ($p = .86$). In the Person-Centred Therapy condition, the SCL-90-R measure *Hostility* did not change significantly over the three time periods $\chi^2(2) = .56$, $p = .76$ ($p > .05$). In the control condition, the SCL-90-R measure also changed significantly over the three time periods $\chi^2(2) = 6.87$, $p = .03$ ($p < .05$). Wilcoxon tests were used for post hoc exploration. A Bonferroni correction was applied and effects are reported at a .0167 level of significance. The measure of *Hostility* did not change significantly from T 1 to T 2, $T = 20.50$, $r = -.13$, ($p = .47$). However, hostility changed marginally from T 1 to T 3, $T = .00$, $r = -.47$, ($p = .026$) but not significantly from T 2 to T 3, $T = 6$, $r = -.21$, ($p = .34$).

Short-term Effects

There was a significant main effect for time, $F(1, 28) = 5.36$, $p = .03$, η^2 partial = .16. The interaction effect between group and time of measurement was also significant, $F(2, 28) = 4.33$, $p = .023$, η^2 partial = .24. Simple effect analysis reveals that the effect is significant in the Art Therapy group, $F(1, 9) = 5.07$, $p = .05$, η^2 partial = .36, but not in the other two groups. Simple contrasts show that at the follow up measurement T2, *Hostility* scores were significantly lower than at baseline for women in the Art Therapy group. The main effect for group was not significant, $F(2, 28) = 3.11$, $p = .06$, η^2 partial = .18.

Subscale *Phobic Anxiety*

There was a statistically significant large main effect of time, $F(2, 36) = 20.34, p = .00, \eta^2 \text{ partial} = .53$. Simple contrasts revealed that phobic anxiety at T 2 and T 3, was significantly higher than at T 1, $F(1, 18) = 19.37, p < .01$ and $F(1, 18) = 33.29, p < .01$. The means are presented in table 8 below. There was also a significant, interaction effect between therapy group and time of data collection, $F(4, 36) = 3.89, p = .01, \eta^2 \text{ partial} = .30$. Figure 4.14. illustrates the interaction, indicating that there are differences in phobic anxiety across the three time points for all groups. Simple effect analysis reveals that the effect is significant in both treatment conditions but not in the control condition. Simple contrasts show that in the Art Therapy condition, phobic anxiety was significantly lower than at baseline. In the Person-Centred condition, phobic anxiety was significantly lower than baseline only at T 3. The main effect for group did not reach statistical significance, $F(2, 18) = .21, p = .81$, the effect size was very small however ($\eta^2 \text{ partial} = .02$).

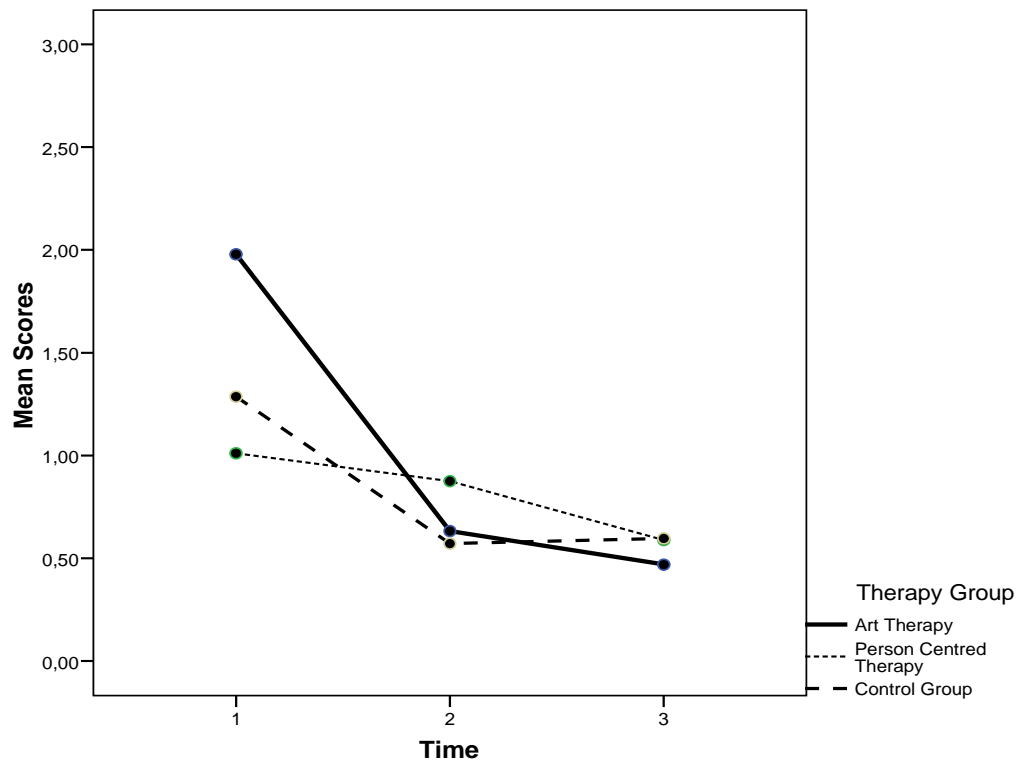


Figure 4.14. Profile Plot for Phobic Anxiety

Subscale *Phobic Anxiety*, Friedman's test

In the Art Therapy condition, the SCL-90-R measure of *Phobic Anxiety* changed significantly over the three time periods $\chi^2(2) = 10.38, p = .006$ ($p < .05$). Wilcoxon tests were used for post hoc exploration. A Bonferroni correction was applied and effects are reported at a .0167 level of significance. *Phobic Anxiety* did not change significantly from T1 to T2, $T = 9, r = -.297, (p = .11)$. However, *Phobic Anxiety* changed only marginally from T1 to T3, $T = .00, r = -.47, (p = .026)$ but not significantly from T2 to T3, $T = 1.50, r = -.19, (p = .41)$. The SCL-90-R measure *Phobic Anxiety* did not change significantly over the three time periods in the Person-Centred condition, $\chi^2(2) = 3.60, p = .16$ ($p > .05$) and the control condition $\chi^2(2) = 4.26, p = .12$ ($p > .05$).

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Short term Effects

There was a significant main effect for time, $F(1, 28) = 9.98, p = .00, \eta^2$ partial = .26. Scores on the *Phobic Anxiety* subscale significantly decreased between data collection T 1 and T 2. The interaction effect was not significant $F(2, 28) = 1.35, p = .28, \eta^2$ partial = .09. The main effect for group was also not significant $F(2, 28) = 2.94, p = .12, \eta^2$ partial = .14.

Subscale *Paranoid Ideation*

There was a statistically significant main effect for time, $F(2, 36) = 13.67, p = .00, \eta^2$ partial = .43. Simple contrasts revealed that scores on the subscale *Paranoid Ideation* at T 2 and at T 3, were significantly lower than at T 1 $F(1, 18) = 17.12, p < .01$ and $F(1, 18) = 17.56, p < .01$. The means are presented in table 8 below. The interaction effect was also significant $F(4, 36) = 3.84, p = .01, \eta^2$ partial = .30. Figure 4.15. illustrates the interaction, indicating that there are larger differences in paranoid ideation scores across the three time points for the Art Therapy group. Simple effect analysis reveals that the effect is significant in the Art Therapy condition but not the other two conditions. Simple contrasts show that at both post-treatment time points *Paranoid Ideation* scores were significantly lower at both post-treatment follow up measurements than at baseline for women who participated in Art Therapy. The main effect for group did not reach statistical significance, $F(2, 18) = .13, p = .88$, the effect size was very small however (η^2 partial = .01).

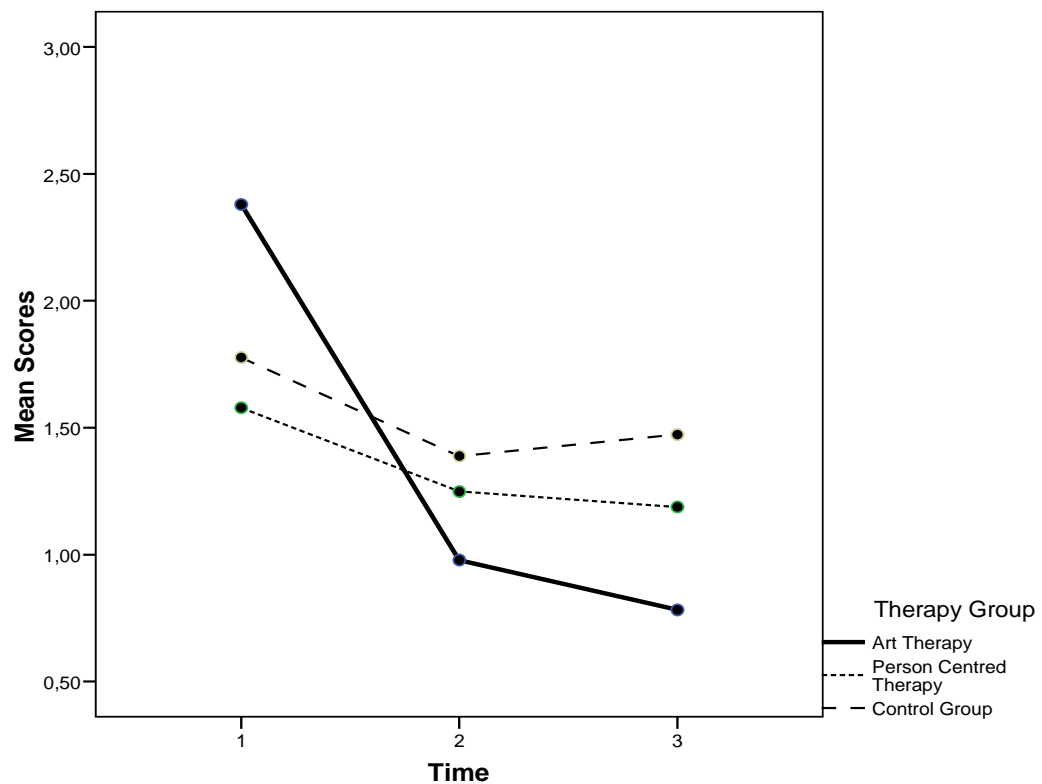


Figure 4.15. Profile Plot for Paranoid Ideation

Short-term Effects

There was a significant main effect for time $F(1, 28) = 12.27, p = .00$, $\eta^2_{\text{partial}} = .31$. Scores on the *Paranoid Ideation* subscale significantly decreased between data collection T 1 and T 2. The interaction effect was not significant $F(2, 28) = 2.58, p = .09, \eta^2_{\text{partial}} = .16$. The main effect for group was also not significant $F(2, 28) = 1.44, p = .25, \eta^2_{\text{partial}} = .09$.

Subscale Psychoticism

Because scores of this subscale were not normally distributed in this sample, a 3 x 3 mixed subjects analysis of variance was conducted with square root transformed scores. There was a statistically significant main effect for time

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$F(2, 36) = 17.56, p = .00, \eta^2 \text{ partial} = .60$. Simple contrasts revealed that scores on the subscale *Psychoticism* at T 3, but not at T 2, was significantly lower than at T 1, $F(1, 18) = 19.30, p < .01$. The means are presented in table 8 below. The interaction effect was also significant $F(4, 36) = 8.61, p = .00, \eta^2 \text{ partial} = .39$. Figure 4.16. illustrates the interaction, indicating that there are larger differences in *Psychoticism* scores across the three time points for the Art Therapy group. Simple effect analysis reveals that the effect is significant in the Art Therapy condition but not in the other two conditions. Simple contrasts show that at both post-treatment time points *Psychoticism* scores were significantly lower at both post-treatment follow up measurements than at baseline for women who participated in Art Therapy. The main effect for group did not reach statistical significance $F(2, 18) = .118, p = .33, \eta^2 \text{ partial} = .12$).

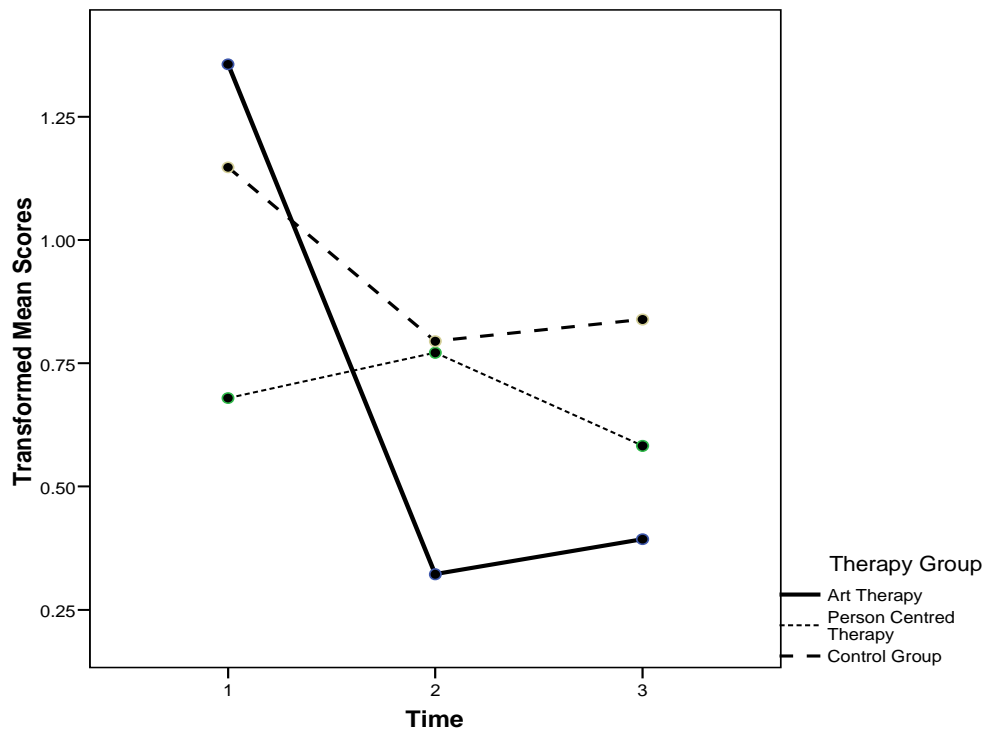


Figure 4.16. Profile Plot for Psychoticism

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Subscale *Psychoticism*, Friedman's test

In the Art Therapy condition, the SCL-90-R measure of *Psychoticism* changed significantly over the three time periods $\chi^2(2) = 12.08, p = .002 (p < .05)$. Wilcoxon tests were used for post hoc exploration. A Bonferroni correction was applied and effects are reported at a .0167 level of significance. Symptoms of *Psychoticism* changed significantly from T 1 to T 2, $T = 2, r = -.48, (p = .009)$. Symptoms changed only marginally from T 1 to T 3, $T = .00, r = -.48, (p = .02)$ or from T 2 to T 3, $T = 4, r = -.09, (p = .71)$.

In the Person-centred Therapy condition, the SCL-90-R measure of *Psychoticism* changed significantly over the three time periods $\chi^2(2) = 6.28, p = .043 (p < .05)$. Wilcoxon tests were used for post hoc exploration. A Bonferroni correction was applied and effects are reported at a .0167 level of significance. *Psychoticism* did not change significantly from T 1 to T 2, $T = 18, r = -.11, (p = .59)$ or from T 1 to T 3, $T = .13.50, r = -.23, (p = .28)$. *Psychoticism* changed marginally from T 2 to T 3, $T = .00, r = -.50, (p = .027)$. In the control condition, the measure *Psychoticism* did not change significantly over the three time periods $\chi^2(2) = 3.22, p = .20 (p > .05)$.

Short-term Effects

There was a significant effect for time, $F(1, 28) = 13.41, p = .00, \eta^2 \text{ partial} = .32$. Scores on this subscale significantly decreased overall for participants between T 1 and T 2 of data collection. The interaction effect was significant, $F(2, 28) = 6.69, p = .004, \eta^2 \text{ partial} = .32$. Simple effect analysis reveals that the effect is significant in the Art Therapy group $F(1, 9) = 11.20, p = .01, \eta^2 \text{ partial} = .56$ and the control group, $F(1, 10) = 2.81, p = .04, \eta^2 \text{ partial} = .37$, but not in the

Person-Centred group. Simple contrasts show that at the follow up measurement T2, *Psychoticism* scores were significantly lower than at baseline for women in these two groups. The main effect for group did not reach statistical significance $F(2, 28) = .78, p = .47, \eta^2 \text{ partial} = .05$].

Table 8

Subscales of the SCL-90-R, differences in means across different points in time

Scale	T1	T2	T3	p
Somatisation	1.60	0.86	0.90	.00**
Obsessive Compulsive	1.87	2.07	1.07	.00**
Interpersonal Sensitivity	1.82	1.06	1.02	.00**
Depression	1.91	1.28	1.09	.00**
Anxiety	1.57	0.84	10.75	.00**
Hostility	1.56	0.78	0.73	.00**
Phobic Anxiety	1.41	0.71	0.55	.00**
Paranoid Ideation	1.56	0.78	0.73	.00**
Psychoticism	1.26	0.60	0.53	.00**
Global Severity Index	1.67	0.98	0.88	.00**

Note. Means of SCL-90-R subscales at three data collection times

4.2.3.5. Coping

Coping responses were measured using the Coping Responses Inventory (CRI). An assessment of coping styles was used primarily to gain predictor variables to explore the relationship of psychological well-being and coping styles (see section 4.1.5. below). A change in styles was therefore not expected.

However, a 3 x 3 mixed subjects analysis of variance was conducted to explore possible effects of different interventions on coping responses over time. Many coping strategies did not change significantly during the course of the study but tended to improve generally over time. There was a change on three avoidance

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coping scales however: *Cognitive avoidance*, *Acceptance/Resignation*, and *Seeking Alternative Rewards*. These differences will be highlighted briefly below.

Avoidance Coping, Cognitive Avoidance

There was a statistically significant main effect of time, $F(2, 36) = 7.70, p = .00, \eta^2 \text{ partial} = .30$. Simple contrasts revealed that this form of coping was significantly different at T 3 than at baseline T 1, $F(1, 18) = 11.73, p < .05$. The interaction between therapy group and time of data collection was not significant, $F(4, 36) = .82, p = .52, \eta^2 \text{ partial} = .08$. The main effect for group also did not reach statistical significance, $F(2, 18) = .95, p = .45, \eta^2 \text{ partial} = .10$.

Avoidance Coping, Acceptance/Resignation

There was a statistically significant main effect of time, $F(2, 36) = 3.62, p = .04, \eta^2 \text{ partial} = .16$. Simple contrasts revealed that this form of coping was significantly different at T 3 than at T 1, $F(1, 19) = 4.85, p < .05$. The interaction between therapy group and time of data collection was not significant, $F(4, 36) = 1.26, p = .30, \eta^2 \text{ partial} = .12$. The main effect for group also did not reach statistical significance, $F(2, 19) = .49, p = .62, \eta^2 \text{ partial} = .05$.

Avoidance Coping, Seeking Alternative Awards

There was a statistically marginally significant main effect of time, $F(2, 36) = 3.23, p = .05, \eta^2 \text{ partial} = .15$. Simple contrasts revealed that this coping strategy at T 2, but not T 3, was significantly higher than at T 1 $F(1, 18) = 7.14, p < .05$. There was also a significant interaction effect between therapy group and time of data collection, $F(4, 36) = 3.25, p = .02, \eta^2 \text{ partial} = .27$. The main effect

for group did not reach statistical significance, $F(2, 19) = .79, p = .47, \eta^2 \text{ partial} = .08$.

4.2.3.6. Trauma Symptom Inventory

Symptoms of trauma indicating a diagnosis of PTSD were measured with the Trauma Symptom Inventory. In order to examine the differential effects of the three interventions on trauma symptoms reported by participants over all three point in time a 3 x 3 mixed subjects analysis of variance was conducted. Results for all subscales, with the exception of the three control scales, will be described below.

Subscale *Anxious Arousal*

There was a statistically significant large main effect of time, $F(2, 36) = 10.05, p = .00, \eta^2 \text{ partial} = .36$. Simple contrasts revealed that *Anxious Arousal* at T2, as well as at T3, was significantly lower than at T1, $F(1, 18) = 11.40, p < .05$ and $F(1, 18) = 14.42, p < .05$). The means are presented in table 10 below. There was also a significant, large, interaction effect between therapy group and time of data collection, $F(4, 36) = 3.14, p = .03, \eta^2 \text{ partial} = .26$. Figure 4.20. illustrates the interaction, indicating that there are larger differences in anxious arousal between T1 and T2 for the Art Therapy group than for the other two therapy groups. Simple effect analysis reveals that even though all three groups greatly decreased anxious arousal the effect is only significant for the Art Therapy group between T1 and T2. Simple contrasts show that at T3 anxious arousal was significantly lower than at baseline for all groups. The main effect for group did not reach statistical significance $F(2, 18) = .07, p = .93, \eta^2 \text{ partial} = .01$.

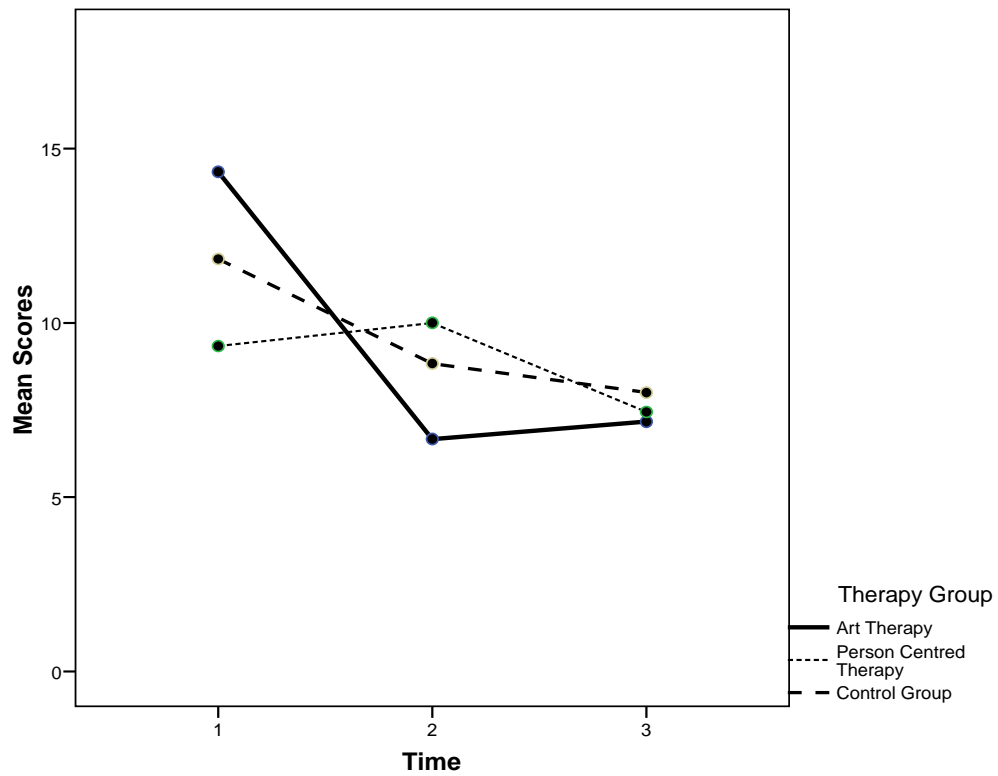


Figure 4.17. Profile Plot for Anxious Arousal

Short-term Effects

There was a significant main effect for time, $F(1, 30) = 12.05, p = .00, \eta^2$ partial = .29. Scores on the TSI subscale *Anxious Arousal* significantly decreased overall for participants between T 1 and T 2 of data collection. The interaction effect between intervention group and time of data collection did not reach statistical significance, $F(2, 30) = 2.58, p = .09, \eta^2$ partial = .15. The main effect for group was also not significant, $F(2, 30) = 1.15, p = .33, \eta^2$ partial = .07.

Subscale *Depression*

There was a statistically significant large main effect of time, $F(2, 36) = 9.19, p = .00, \eta^2$ partial = .39. Simple contrasts revealed that depression at T 2, as

well as at T 3, was significantly lower than at T 1, $F(1, 18) = 12.57, p < .05$ and $F(1,18) = 12.62, p < .05$. The means are presented in table 10 below. There was also a significant, large, interaction effect between therapy group and time of data collection, $F(4, 36) = 2.99, p = .03, \eta^2 \text{ partial} = .25$. Figure 4.21. illustrates the interaction, indicating that there are larger differences in depression across the three measurement points for both intervention groups. Simple effect analysis indicates that the depression is significantly lower in participants in the Art Therapy and the Person-Centred therapy groups but not for women in the control group. The effect it is only significant for the Art Therapy group between T 1 and T 2 (and for the Person-Centred group between T 2 and T 3). The main effect for group did not reach statistical significance, $F(2, 18) = .13, p = .88, \eta^2 \text{ partial} = .01$.

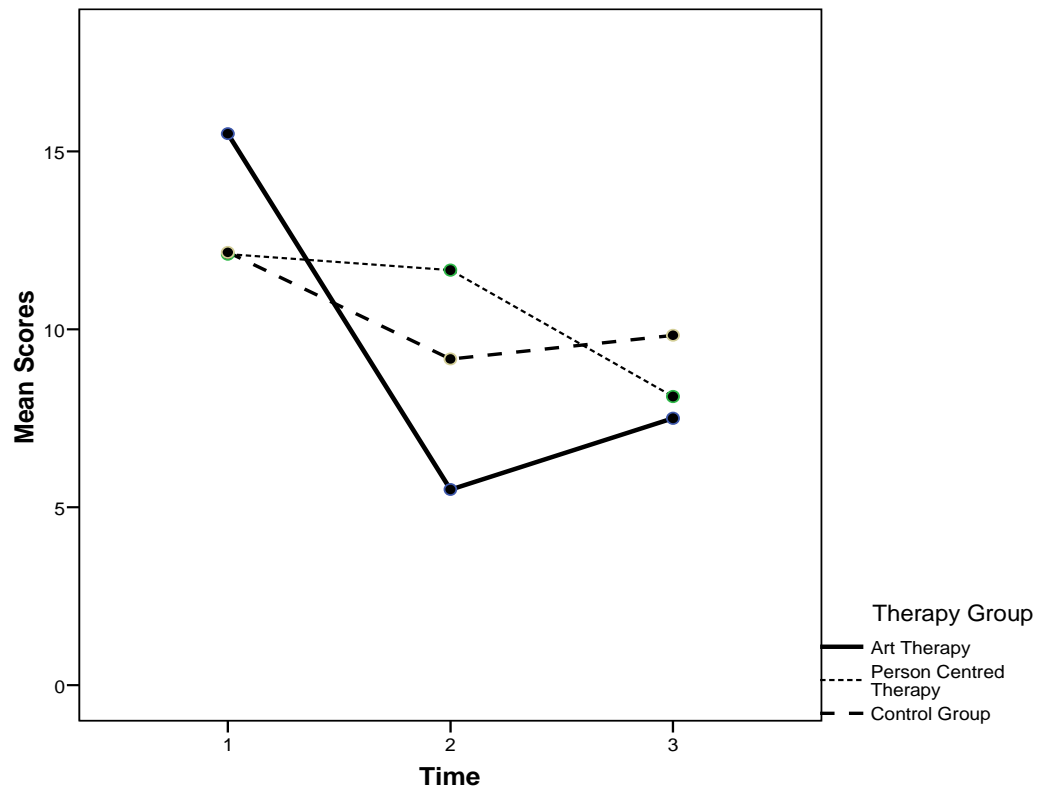


Figure 4.18. Profile Plot for Depression (TSI)

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Short-term Effects

There was a significant main effect for time, $F(1, 30) = 13.39, p = .00, \eta^2$ partial = .31, but not for group $F(2, 30) = 2.07, p = .14, \eta^2$ partial = .12. Scores on the TSI subscale depression significantly decreased overall for participants between T 1 and T 2 of data collection. The interaction effect was not significant, $F(2, 30) = 2.91, p = .07, \eta^2$ partial = .16.

Subscale Anger/Irritability

There was a statistically significant large main effect of time, $F(2, 36) = 17.72, p = .00, \eta^2$ partial = .50. Simple contrasts revealed that *Anger/Irritability* at T 2, as well as at T 3, was significantly lower than at T 1, $F(1, 18) = 13.93, p < .01$ and $F(1, 18) = 33.48, p < .00$). The means are presented in table 10 below. There was also a significant, large, interaction effect between therapy group and time of data collection, $F(4, 36) = 6.17, p = .00, \eta^2$ partial = .41. Figure 4.22 illustrates the interaction, indicating that there are larger differences in anger and irritability across the three time points for the Art Therapy group than for the other two therapy groups. Simple effect analysis reveals that the effect is significant in the Art Therapy group, and not significant in the other groups. Simple contrasts show that at both post-treatment time points anger and irritability was significantly lower than at baseline. The main effect for group was also marginally significant. $F(2, 18) = 3.53, p = .05, \eta^2$ partial = .28. Post hoc tests (Tukey HSD) revealed a significant difference between the Person-Centred group and the control group (Mean difference = $\pm 7.19, SD 2.78, p = .047$). The difference between groups was: Art Therapy = 9.11, Person-Centred Therapy = 7.82, control group = 15.

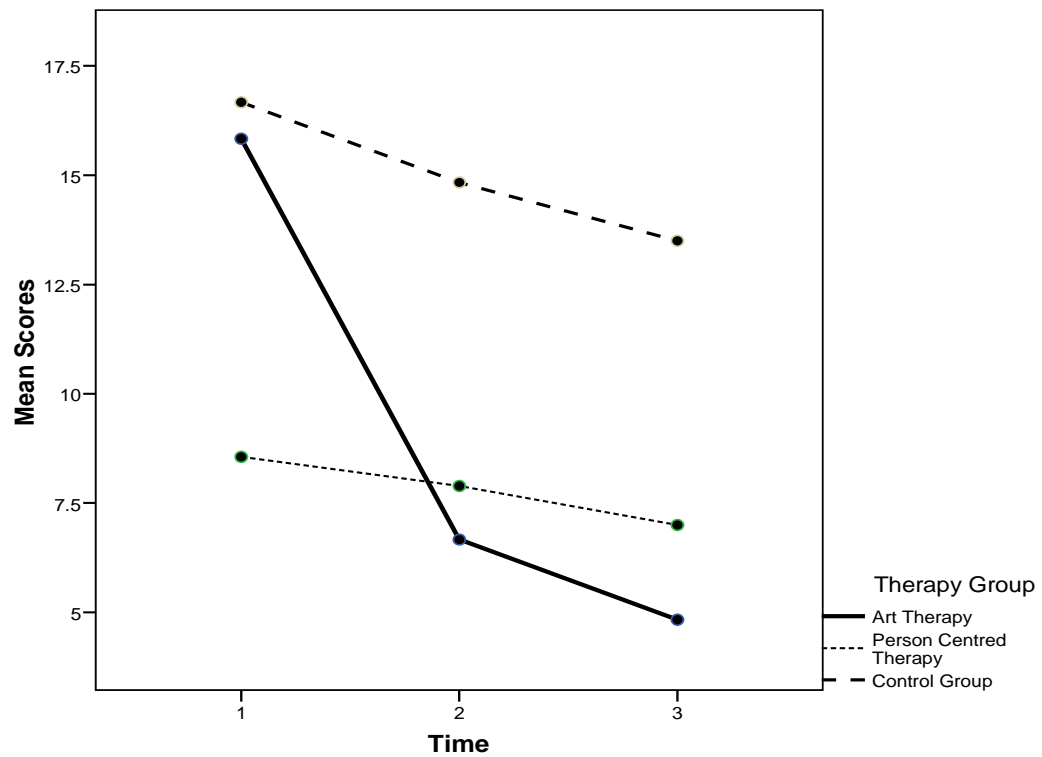


Figure 4.19. Profile Plot for Anger/Irritability

Short-term Effects

There was a significant main effect for time, $F(2, 30) = 12.92, p = .00, \eta^2$ partial = .30, but not for group, $F(2, 30) = 1.37, p = .27, \eta^2$ partial = .08. Scores on the TSI subscale *Anger/Irritability* significantly decreased overall between T 1 and T 2 of data collection. The interaction effect was also significant $F(2, 30) = 3.47, p = .04, \eta^2$ partial = .19. Simple effect analysis reveals that the effect is significant in the Art Therapy group $F(1, 9) = 12.20, p = .01, \eta^2$ partial = .58, and not in the other two groups. Simple contrasts show that at the follow up measurement T 2, *Anger/Irritability* scores were significantly lower than at baseline for women in this group.

Subscale *Intrusive Experiences*

There was a statistically significant large main effect of time, $F(2, 36) = 10.60, p = .00, \eta^2 \text{ partial} = .37$. Simple contrasts revealed that *Intrusive Experiences* at T 2, as well as at T 3, were significantly higher than at T 1, $F(1, 18) = 10.29, p < .01$ and $F(1, 18) = 16.10, p < .01$. The means are presented in table 10 below. The interaction effect between therapy group and time of data collection was not significant ($F[4,36] = 0.94, p = .45, \eta^2 \text{ partial} = .10$). The main effect for group did not reach statistical significance [$F(2,18) = 2.02, p = .16, \eta^2 \text{ partial} = .18$].

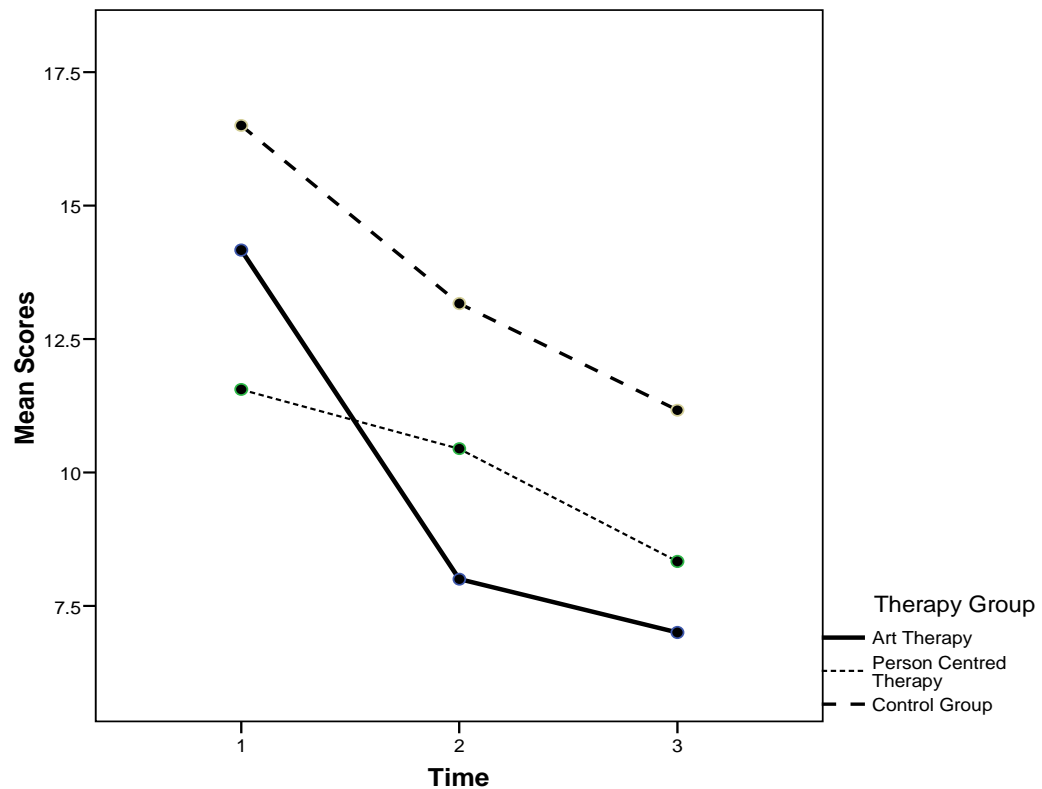


Figure 4.20. Profile Plot for Intrusive Experiences

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Short-term Effects

There was a significant main effect for time, $F(1, 30) = 12.16, p = .00, \eta^2$ partial = .29, but not for group $F(2, 30) = .21, p = .81, \eta^2$ partial = .01. Scores on the TSI subscale *Intrusive Experiences* significantly decreased overall between T 1 and T 2 of data collection. The interaction effect was not significant $F(2, 30) = 1.52, p = .24, \eta^2$ partial = .09.

Subscale *Defensive Avoidance*

There was a statistically significant large main effect of time $F(2, 36) = 10.86, p = .00, \eta^2$ partial = .38. Simple contrasts revealed that *Defensive Avoidance* at T 2, as well as at T 3, were significantly lower than at Time 1, $F(1, 18) = 13.54, p < .01$ and $F(1, 18) = 16.32, p < .01$. The means are presented in table 10 below. The interaction effect between therapy group and time of data collection was not significant, $F(4, 36) = 1.18, p = .34, \eta^2$ partial = .12. However, the main effect for group was significant $F(2, 18) = 5.02, p = .02, \eta^2$ partial = .36. The mean difference for groups was: Art Therapy = 9.72, Person-Centred Therapy = 12.99 and control group = 15.06. A Tukey HDS post hoc test was performed to explore differences between groups. A significant difference was found between the Art Therapy group and the control group (mean difference = -5.33 *SD* 1.70, $p = .02$).

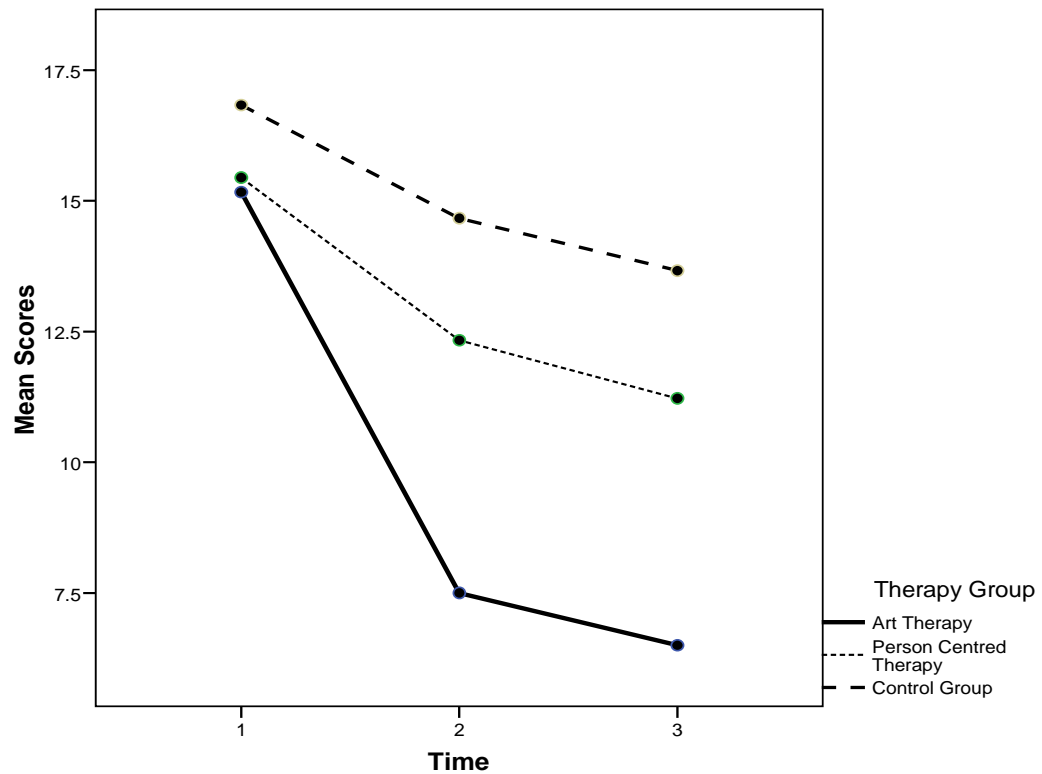


Figure 4.21. Profile Plot for Defensive Avoidance

Short-term Effects

There was a significant main effect for time, $F(2, 30) = 4.19, p = .05, \eta^2$ partial = .12, but not for group, $F(2, 30) = 1.93, p = .16, \eta^2$ partial = .11. Scores on the TSI subscale *Defensive Avoidance* significantly decreased overall between T 1 and T 2 of data collection. The interaction effect was not significant, $F(2, 30) = .66, p = .52, \eta^2$ partial = .04.

Subscale *Dissociation*

There was a statistically significant large main effect of time, $F(2, 36) = 7.96, p = .00, \eta^2$ partial = .31. Simple contrasts revealed that dissociation experiences at T2, as well as at T3, were significantly lower than at T1, $F(1, 18) =$

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10.82, $p < .01$ and $F(1, 18) = 10.32$, $p < .01$. The means are presented in table 10 below. The interaction effect between therapy group and time of data collection was not significant $F(4, 36) = 1.49$, $p = .23$, η^2 partial = .14. The main effect for group also did not reach statistical significance $F(2, 18) = .29$, $p = .75$, η^2 partial small = .03.

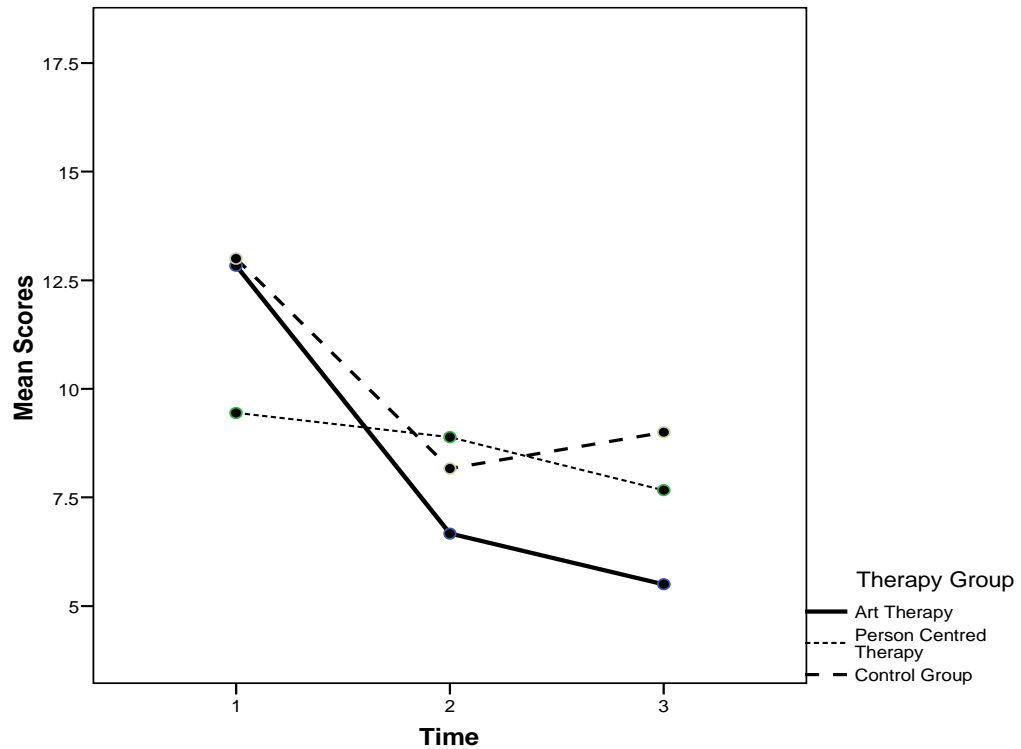


Figure 4.22. Profile Plot for Dissociation

Short-term Effects

There was a significant main effect for time $F(1, 30) = 6.97$, $p = .01$, η^2 partial = .19, but not for group, $F(2, 30) = .82$, $p = .45$, η^2 partial = .05. Scores on the TSI subscale *Dissociation* significantly decreased overall between T 1 and T 2 of data collection. The interaction effect was not significant $F(2, 30) = .78$, $p = .47$, η^2 partial = .05.

Subscale *Sexual Concerns*

The scores on the TSI Subscale *Sexual Concerns* were not normally distributed. Transformations however, were not effective. The non-parametric alternative to the analysis of variance (Friedman's Test) was chosen in addition to the analysis with non-normally distributed raw scores and will be presented below. Because the assumption of sphericity was violated, multivariate data were used in the report of the results of this subscale. There were no significant main effects for time, $F(2, 17) = 2.03$, $p = .16$, η^2 partial = .20 or group $F(2, 17) = .696$, $p = .51$, η^2 partial = .08. The interaction effect between group and time of data collection was also not significant $F(2, 17) = .73$, $p = .58$, η^2 partial = .08.

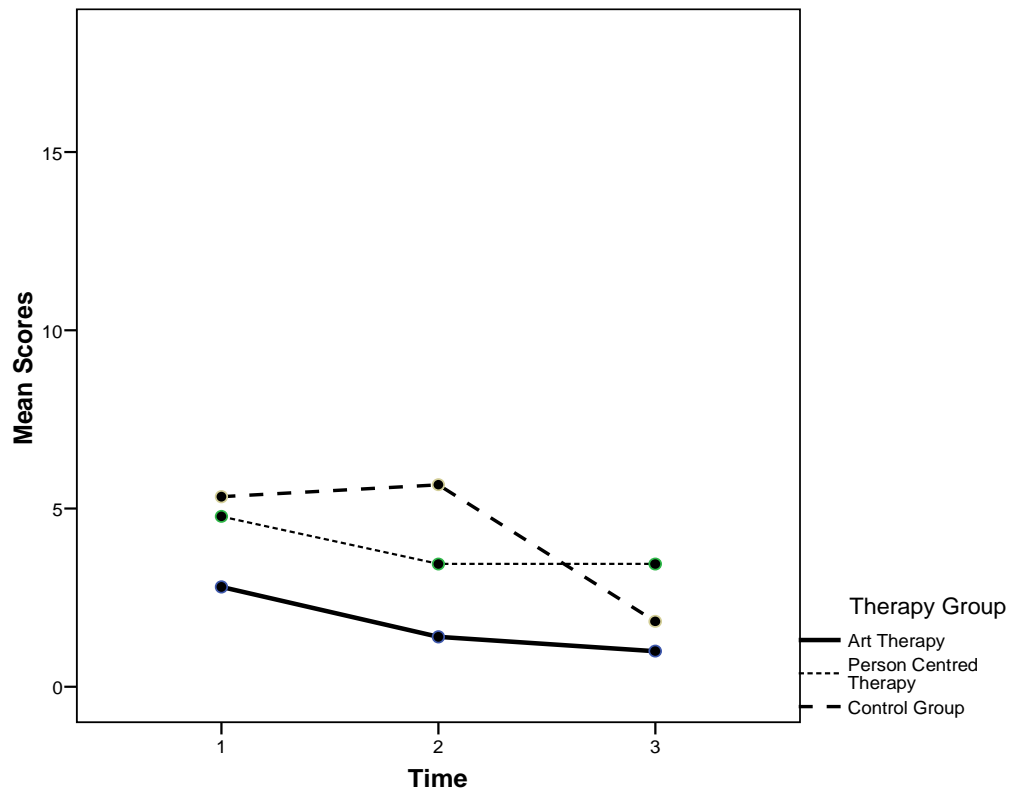


Figure 4.23. Profile Plot for Sexual Concerns

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Subscale *Sexual Concerns*, Friedman's test

The TSI subscale *Sexual Concerns* did not change significantly over the three time periods for the Art Therapy group, $\chi^2(2) = 1.73, p = .42 (p > .05)$, the Person-Centred group $\chi^2(2) = 1.45, p = .49 (p > .05)$, or the control group $\chi^2(2) = 2.00, p = .37 (p > .05)$.

Short-term Effects

There were no significant main effects for time, $F(1, 28) = .65, p = .43, \eta^2 \text{ partial} = .02$, or group, $F(2, 28) = .59, p = .59, \eta^2 \text{ partial} = .04$. The interaction effect was also not significant $F(2, 28) = .06, p = .95, \eta^2 \text{ partial} = .00$.

Subscale *Dysfunctional Sexual Behaviour*

Because score on the TSI subscale *Dysfunctional Sexual Behaviour* were not normally distributed in this sample and transformations were not effective, Friedman's test was chosen in addition to a mixed subjects analysis with raw data. There were no significant main effects for time, $F(2, 36) = 0.80, p = .46, \eta^2 \text{ partial} = .04$ or group, $F(2, 18) = .79, p = .47, \eta^2 \text{ partial} = .08$, for the subscale *Dysfunctional Sexual Behaviour* on the TSI. The interaction effect between group and time of data collection did also not reach statistical significance, $F(4, 36) = 1.65, p = .18, \eta^2 \text{ partial} = .13$.

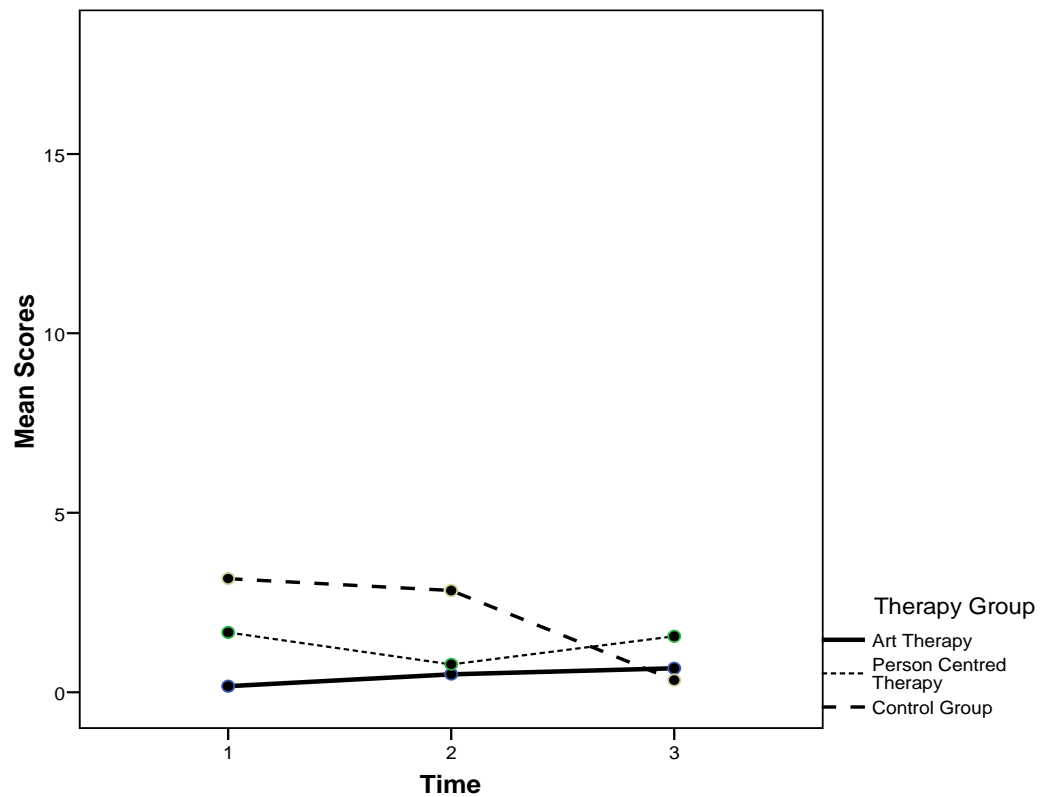


Figure 4.24. Profile Plot for Dysfunctional Sexual Behaviour

Subscale *Dysfunctional Sexual Behaviour*, Friedman's test

The TSI subscale of *Dysfunctional Sexual Behaviour* did not change significantly over the three time periods in the Art Therapy condition, $\chi^2(2) = 4.00, p = .82 (p > .05)$ the Person-Centred condition, $\chi^2(2) = .00, p = .1.00 (p > .05)$, or the control condition. $\chi^2(2) = 3.80, p = .15 (p > .05)$.

Short-term Effects

There were no significant main effects for time, $F(1, 30) = .07, p = .79, \eta^2$ partial = .00 or group, $F(2, 30) = 1.16, p = .33, \eta^2$ partial = .07. The interaction effect was also not significant, $F(2, 30) = .00, p = .99, \eta^2$ partial = .00.

Subscale *Impaired Self-reference*

Because score on the TSI subscale *Impaired Self-reference* were not normally distributed in this sample, all data were square root transformed. There was a statistically significant large main effect of time, $F(2, 36) = 14.87, p = .00, \eta^2 \text{ partial} = .45$. Simple contrasts revealed that impaired self references at T 2, as well as at T 3, was significantly lower than at T 1, $F(1, 18) = 19.17, p < .01$ and $F(1, 18) = 22.12, p < .00$. The means are presented in table 10 below. There was also a significant interaction effect between therapy group and time of data collection, $F(4, 36) = 2.96, p = .03, \eta^2 \text{ partial} = .25$. Figure 4.28. illustrates the interaction, indicating that there are large differences in this measure across the three time points for the three groups. Simple effect analysis reveals that between T1 and T2 the effect is significant in the Art Therapy group, and the control group. After the intervention, between T2 and T3, the effect is only significant for the Person-Centred group but not for the other two groups. Simple contrasts however show that, for women in the Art Therapy group, at both post-treatment time points *Impaired Self-reference* was significantly lower than at baseline. The main effect for group did not reach statistical significance, $F(2, 18) = 1.35, p = .29, \eta^2 \text{ partial} = .13$.

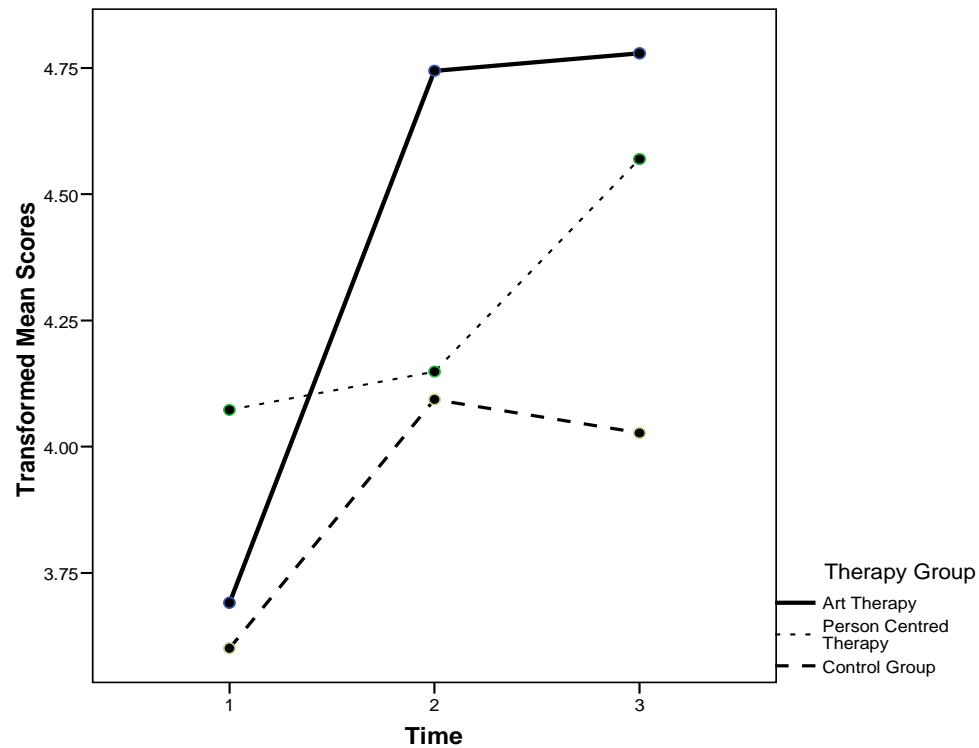


Figure 4.25. Profile Plot for Impaired Self-reference

Subscale *Impaired Self-reference*, Friedman's test

In the Art Therapy condition, the TSI subscale of *Impaired Self-reference* changed significantly over the three time periods, $\chi^2(2) = 9.00, p = .01$ ($p < .05$). Wilcoxon tests were used for post hoc exploration. A Bonferroni correction was applied and effects are reported at a .0167 level of significance. *Impaired Self-reference* scores changed significantly from T 1 to T 2, $T = 1.50, r = -.48, (p = .01)$, but not from T 1 to T 3, $T = 0, r = -.46, (p = .03)$ or from T 2 to T 3, $T = 10, r = .03, (p = .92)$. Similarly, in the Person-Centred Therapy condition, scores on this TSI subscale also changed significantly over the three time periods, $\chi^2(2) = 12.06, p = .002, (p < .05)$. Wilcoxon tests were used for post hoc exploration. A Bonferroni correction was applied and effects are reported at a .0167 level of

significance. *Impaired Self-reference* scores did not change significantly from T 1 to T 2, $T = 12$, $r = -.25$, ($p = .21$), but from T 1 to T 3, $T = 0$, $r = -.53$, ($p = .01$) and from T 2 to T 3, $T = 0$, $r = -.57$, ($p = .01$). In the control condition, scores on the TSI subscale of *Impaired Self-reference* did not change significantly over the three time periods, $\chi^2 (2) = 3.60$, $p = .17$ ($p > .05$).

Short-term Effects

There was a significant main effect for time, $F(1, 30) = 16.71$, $p = .00$, η^2 partial = .36, but not for group, $F(2, 30) = .33$, $p = .72$, η^2 partial = .02. Scores on the TSI subscale *Impaired Self-reference* significantly decreased overall between T 1 and T 2 of data collection. The interaction effect was not significant, $F(2, 30) = .231$, $p = .12$, η^2 partial = .13.

Subscale *Tension-reduction Behaviour*

There was a statistically significant large main effect of time, $F(2, 36) = 10.37$, $p = .00$, η^2 partial = .38. Simple contrasts revealed that tension-reduction behaviour at T 2, as well as at T 3, significantly decreased in comparison to T 1, $F(1, 17) = 4.61$, $p < .05$ and $F(1, 17) = 18.08$, $p < .01$. The means are presented in table 10 below. There was also a significant interaction effect between therapy group and time of data collection, $F(4, 36) = 3.88$, $p = .01$, η^2 partial = .31. Figure 4.29. illustrates the interaction, indicating that there are large differences in this measure for the Art Therapy group. Simple effect analysis reveals that between T1 and T3 the effect is significant only in the Art Therapy group, but not in the other groups. Simple contrasts show that, for women in the Art Therapy group, at T3 tension reduction behaviour had significantly decreased in comparison to baseline.

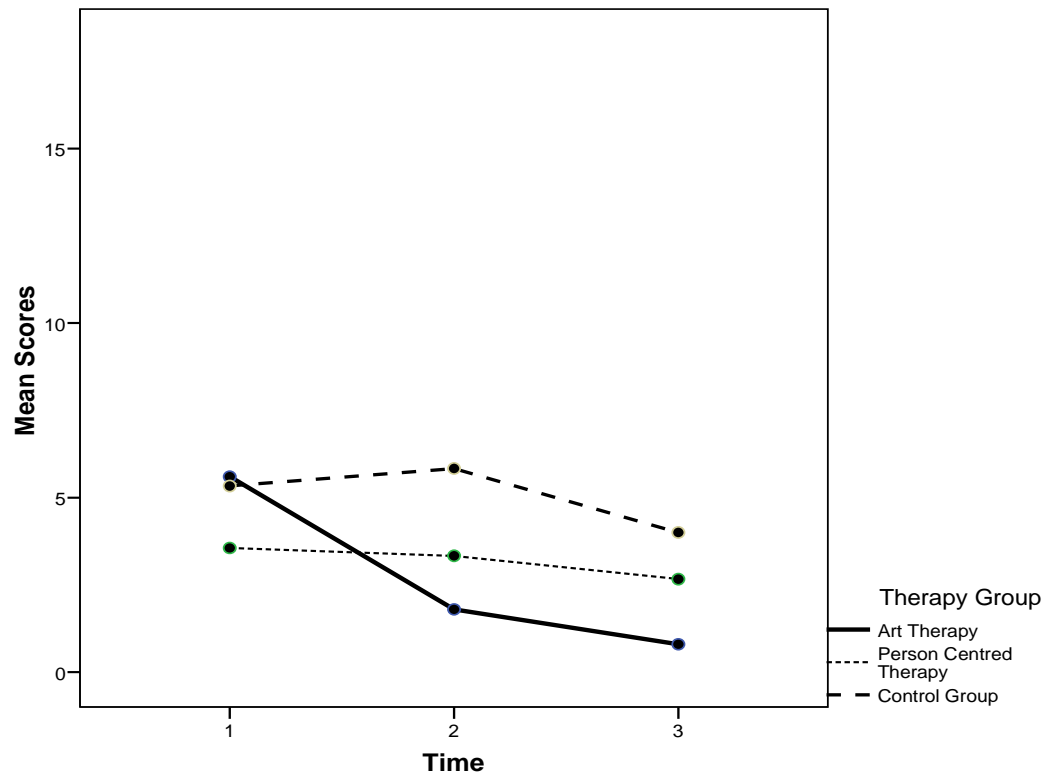


Figure 4.26. Profile Plot for Tension Reduction Behaviour

Subscale *Tension-reduction Behaviour*, Friedman's test

In the Art Therapy condition, the TSI subscale of *Tension Reduction Behaviour* changed significantly over the three time periods, $\chi^2(2) = 8.32, p = .02$ ($p < .05$). Wilcoxon tests were used for post hoc exploration. A Bonferroni correction was applied and effects are reported at a .0167 level of significance. Tension reduction behaviour changed significantly from T 1 to T 2, $T = 0, r = -.51, (p = .007)$, but not from T 1 to T 3, $T = 0, r = -.43, (p = .04)$ or from T 2 to T 3, $T = 1.50, r = -.32, (p = .197)$. The scores on the TSI subscale of *Tension Reduction Behaviour* did not change significantly over the three time periods in the Person-Centred group $\chi^2(2) = 2.00, p = .37$ ($p > .05$) or the control group $\chi^2(2) = 2.95, p = .23$ ($p > .05$).

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Short-term Effects

There was a significant main effect for time, $F(1, 30) = 6.56, p = .01, \eta^2$ partial = .18, but not for group, $F(2, 30) = .15, p = .87, \eta^2$ partial = .01. The interaction effect was also significant, $F(2, 30) = 5.11, p = .01, \eta^2$ partial = .25. Simple effect analysis reveals that the effect is significant in the Art Therapy group, $F(1, 9) = 12.65, p = .01, \eta^2$ partial = .58, and not in the other two groups. Simple contrasts show that at the follow up measurement T 2, *Tension Reduction Behaviour* scores were significantly lower than at baseline for women who had participated in Art Therapy.

Table 9

Differences in means on the TSI subscales across different data collection points

Scale	T1	T2	T3	P
Anxious Arousal	11.48	8.76	7.52	.00
Depression	13.10	9.19	8.43	.00
Anger/Irritability	12.95	9.52	8.24	.00
Intrusive Experience	13.71	10.52	8.76	.00
Defensive Avoidance	15.76	11.62	10.57	.00
Dissociation	11.43	8.05	7.43	.00
Impaired Self-reference	12.86	9.10	7.57	.00

Table 10

Short and long-term effect sizes (Cohen's d) for primary outcome measure at both follow-up measures in comparison to baseline

	AT		PCT		Control	
	<i>T2</i>	<i>T3</i>	<i>T2</i>	<i>T3</i>	<i>T2</i>	<i>T3</i>
GSE	1.1	0.37	0.29	0.79	0.13	-0.12
RSE	0.73	0.40	0.14	1.36	0.67	0.84
BDI II	-1.61	-1.55	-0.05	-1.24	-0.67	-0.15
SCL-GSI	-1.38	-1.60	-0.19	-0.78	-0.92	-0.64
TSI,						
Anxious Arousal	-0.76	-0.86	-0.19	-0.88	-1.03	-0.80
TSI, Intrusive	-0.65	-1.09	-0.27	-0.97	-0.81	-0.75
Experiences						
TSI	-0.68	-1.69	-0.82	-1.22	-0.33	-0.59
Def. Avoidance						

Note. Values of Cohen's d: Scores of T2 or T3, respectively were subtracted from baseline scores and standardised (divided) by baseline standard deviation

4.2.4. Differences between drop outs and completers

Chi Square explorations and one way analyses of variance were conducted to highlight possible differences between participants who completed the questionnaires at all three measurement points and those who dropped out in the course of the study. Several variables have been examined. There were no differences in drop out rates between the groups.

4.2.4.1. Intervention

Nineteen women (37% of the entire sample) took part in the Art Therapy Intervention. Of those women 36.8% (7 participants) completed the study and provided information at all three time points. Forty two percent (8 participants) provided only baseline information and 21.1% (4 participants) provided baseline and follow-up 1 data. Fourteen women (27.5% of the sample) took part in Person-Centred Group Therapy, of which 64.3% (9 participants) completed the study.

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Four women (28.6%) of that intervention group completed only baseline data. Only one further participant (7.1%) dropped out after completing baseline (T1) And follow-up (T2) questionnaires. Eighteen women (35%) agreed to participate in the study as part of the control condition. Of those women, 44% (8 participants) completed the study and provided data at all three time points. Twenty eight percent (5 participants) provided only baseline data and a further 28% (5 participants) provided baseline and T2 data (i.e. dropped out after the first follow up). Altogether 33% (17 women) completed only baseline data, 19.6% (10 women) provided baseline and T2 data, and 47.1% completed the study thereby providing information at all three data collection points. Most women (64%) in the Person-Centred group completed the study whereas the Art Therapy group had the most drop-outs. As the test statistic (chi square) was not significant we can conclude that there is no difference between the type of group and the attrition ratio. (chi square = .44).

Table 11

Attrition rates between experimental groups

Condition	T1	T2	T3
Art Therapy	19 (100%)	12 (63.2%)	7 (36.8%)
Person-Centred Therapy	14 (100%)	10 (71.4%)	9 (64.3%)
Control	18 (100%)	10 (55.6%)	8 (44.4%)
Total	51 (100%)	27 (52.9)	24 (47.1)

Note a. Number of participants and percentage of drop out

4.2.4.2. Occupation and Education

Many women who only completed the baseline data (44%) worked in unskilled or semi-skilled manual positions. Of those who provided baseline data

and completed the questionnaires again at Time 2, 50% were unemployed and 38% were in skilled manual work positions. Of those women who completed the study 25% were skilled manual workers, 25% were unskilled manual workers and 21% were unemployed. Similarly, those women who dropped out of the study after providing only baseline data had no education (21%) or GCSE level education (36%). The majority of women (57%) who completed the questionnaires at baseline and Time 2 (follow-up) had a vocational qualification only (NVQ).

4.2.4.3. Psychopathology

In a further exploration and comparison of participants who dropped out or completed the study, one way between groups analysis of variance was used. The status of drop-out/completers was used as the independent variable with three levels. Participants could have provided baseline data only (level 1, drop-out), baseline and follow up (T 2) data (level 2, drop-out) or could have completed the questionnaires at all three points in time (level 3 – completer). Participants were compared by scores on questionnaires at baseline data collection.

There was no significant difference between women who completed the study or those who dropped out after baseline or T 2 collection on the measures of self-efficacy, self-esteem, depression or any coping response. Some significant differences were apparent on two subscales of the SCL-90-R: *Somatisation* and *Paranoid ideation*, $F(2, 44) = 3.50, p = .04, \eta^2 = .14$ and $F(2, 44) = 3.52, p = .04, \eta^2 = .14$. Post hoc comparisons using Tukey HSD indicated that on both subscales the difference was found between completers of baseline data only (level 1) and baseline and follow up completers (level 2). In both cases, women who dropped out after only completing baseline data indicated higher scores on the measures

than those who completed both T1 and T2. Further differences were found on the subscales of *Depression*, $F(2, 45) = 3.91, p = .03, \eta^2 = .15$, *Dissociation*, $F(2, 45) = 7.80, p = .00, \eta^2 = .26$, *Dysfunctional Sexual Behaviour*, Welch (2, 20.23) = 4.64, $p = .02, \eta^2 = .26$, *Impaired Self-reference*, $F(2, 45) = 4.25, p = .02, \eta^2 = .16$ and *Tension Reduction*, Welch (2, 20.05) = 3.76, $p = .04, \eta^2 = .15$ of the TSI. On the subscale of *Dysfunctional Sexual Behaviour*, women in all drop-out/completer categories were significantly different from each other. On the other five subscales, differences were found between women who completed baseline data only (level 1) and women who completed baseline and T 2 data (level 2). In all cases, women who dropped out after completing only baseline data reported higher scores on all measures (indicating greater psychopathology) than women who completed the questionnaires again a second time.

4.2.5. Predictors of Therapeutic Success

Several non-parametric correlations between therapy outcome measures (i.e. self-efficacy, self-esteem, depression and global severity) and time of the abusive relationship as well as time since leaving the perpetrator have been conducted. The analyses showed no correlation between time of and since the relationship and psychopathology at baseline ($p > .05$), with the exception of time since leaving the abuser and self esteem (*Spearman's rho* .28 $p = .05$). There was a trend towards more self esteem the longer an abusive relationship had been left.

Simple correlations were used to explore relationships between well-being variables such as self-efficacy and coping strategies at baseline and with data collected on these measures at follow-up. A strong positive correlation was found between the amount of perceived self-efficacy reported by women at baseline and

self-esteem indicated by participants at ten weeks later follow up. The less self-efficacy women had at the beginning, the lower the self-esteem even after the intervention, $r = .59, p < .05$. A negative relationship was found between self-efficacy at baseline and the level of depression after the intervention (the less self-efficacy the more depressed women were even after the intervention) $r = -.50, p < .05$.

The relationship between coping techniques and psychological well-being was also explored in detail. A positive relationship between the active coping strategy of *Positive Reappraisal* and self-esteem was discovered. In this case, the more able women were to use positive coping mechanisms such as positive reappraisal the more self-esteem they had (and vice versa), $r = .37, p < .05$. Similarly, a negative relationship between avoidance coping techniques such as *Acceptance/Resignation* and the level of self-esteem was also found (the more women resigned, the less self-esteem they had – or low-self esteem contributed to them resigning more) $r = -.38, p < .05$. A strong negative correlation between the level of self-esteem at baseline and global severity of symptoms at follow up was also found. The higher women scored on self-esteem at the beginning, the lower the reported global severity at follow up, $r = .53, p < .05$. The level of self-esteem at baseline was also negatively related to the level of depression at the outcome (the higher self-esteem at baseline, the lower the depression at follow up) $r = -.59, p < .05$. Also, symptoms of depression at baseline were also related to the global severity of symptoms and the level of depression at outcome (global severity, $r = .59, p < .001$ and depression, $r = .55, p = .001$). The higher the reported depression at the beginning of the study, the higher were the global severity scores as well as depression scores at follow up. Coping strategies were further explored

in regard to symptoms of PTSD. *Anxious Arousal* at the follow-up measure was negatively related to *Positive Reappraisal* at baseline ($r = -.40, p < .05$) and positively correlated with *Acceptance and Resignation* also at baseline ($r = .35, p < .05$). The more women were able to use positive reappraisal at the baseline, the less anxious they were at follow-up. Similarly, the more they used resignation as coping strategy the more anxious they were at follow up.

The level of psychopathology therefore did not seem to impact outcomes further but did seem to impact whether women remained in the study. Women with higher self-esteem and higher perceived self-efficacy also do better several weeks later and report fewer symptoms of mental ill-health.

4.3. Results of the Qualitative Analysis

The main focus of the current study is the effect of Art Therapy for survivors of IPV. Although a number of improvements were also reported by participants in the Person-Centred condition, quantitative analyses of data revealed that participants in the Art Therapy condition reported improvements in several areas before women in other conditions. In particular, Art Therapy was more effective than Person-Centred Therapy in decreasing symptoms of trauma. A thorough analysis of interviews solely with research participants who had attended the Art Therapy groups was therefore chosen to further investigate the effectiveness of the intervention from the viewpoint of participants. Interviews were conducted in order to explore the personal experiences women had with Art Therapy, the medium of art and the therapeutic process. The purpose of the interviews was also to discover factors that made this intervention effective for survivors. By using thematic analysis and the process outlined by Braun and Clarke (2006), several themes and sub-themes were extracted from the interviews with Art Therapy participants and are discussed in the following section. Although participants used the interview time to discuss multiple aspects of their experience, the following analysis focuses mainly on the outcome of Art Therapy as described by participants. Other areas of women's interest are only briefly discussed. Necessary therapeutic elements for survivors as well as implications for practice are also mentioned as they present an important consideration for professionals. As a result of the interviews, beneficial and effective elements of therapy with survivors could be identified and many suggestions for change and improvement were given for the future application of Art Therapy with survivors of IPV.

4.3.1. The Experience of Art Therapy

All interviewees admitted that Art Therapy was an unfamiliar concept and none of them had previously participated in this form of therapy. During the interview it became clear that only taking part in this research project gave these women the opportunity to experience Art Therapy during their involvement with a domestic violence agency. Reasons for participation in and expectations of therapy were manifold and included curiosity, obligation to do something for other survivors of violence or wanting to help the researcher. Some women also came to the group because they felt that they needed to gain self worth and independence after leaving their partners and the study offered the opportunity. Routine interventions, including key workers, were often not considered sufficient in accomplishing that goal. As mentioned in previous sections, Art Therapy has been successfully applied in domestic violence agencies (Lagorio, 1989; Palmquist, 2003; Stokrocki et al., 2004) but is still an uncommon method of treatment. As Lagorio (1989) points out “the application of art therapy to mandatory weekly support sessions proved to be an effective tool in terms of education, identification of feelings, and, in general, an enjoyable engagement with the art-making process itself, oftentimes evoking hidden feelings as well as latent talents” (p.96). A similar experience has been made by women in the current study. They expressed a positive, albeit somewhat sceptical, attitude towards therapy in general as well as Art Therapy. Several women had already experienced a different form of therapy, such as individual counselling, in the past and scepticism might have been due to the lack of experience with and knowledge of Art Therapy. After taking part however, the attitude expressed by all interviewees towards the intervention and about their experience in therapy was a

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positive one. Some participants significantly changed their view of the intervention and considered Art Therapy a highly valued approach once the sessions had come to an end. One participant mentioned a lack of positive experiences with other forms of therapy, whereas Art Therapy “worked for her”. Opinions about the women’s experiences ranged from simply “fun” to a valued journey of self-discovery.

Much time was spent during the interviews to discuss the process of Art Therapy, pointing out the differences between this form of intervention in comparison with more traditional approaches to therapy with which several participants were familiar. As outlined by Edwards (2004), despite the importance of language and words, the philosophy of Art Therapy builds on the premise that human experience cannot be entirely reduced to words and that some emotional states are beyond words. This idea was often reflected by the women who discussed their experience with the researcher. The use of art as well as the structure of sessions were discussed and explained by participants in their attempts to describe their experiences. Participants spoke at length about their experience of Art Therapy and had a variety of ways to explain the therapy process. Women valued art as an expression, the group process and the emotional impact of their art work.

It was clear that for all participants, Art Therapy represented an alternative way to communicate and a valuable means of expression. One participant compared Art Therapy to using a mirror for the inner self, or a way to bring out thoughts and emotions that are not normally part of her awareness.

It is art, but what’s happened, it’s like your inner self, like a mirror self you are putting on paper. You know if you’re upset, it’s gonna come out

on paper. You know it's, you can't hide it and it gets things off your chest. (*Participant K.*)

In line with other current applied Art Therapy programs, the art process, as well as the art work itself, were used as expressions of participant's thoughts and emotions (Smeijsters & Cleven, 2006). Once participants were used to using the medium of art, it became easier to use it to their advantage. Art therapy is said to offer advantages for a variety of populations, such as alleviation of immediate crisis situations through catharsis, engaging depressed individuals and particularly providing opportunities for the expression of pent-up emotions (Merriam, 1998). According to participants, emotions put on paper came out of the heart, whereas verbal expression might have been less raw, filtered and thought about before being articulated.

Talking is good but when you're drawing, its coming out of your heart and it's like, a burden has been lifted and you don't realise, but it's just like burden has been lifted. And, and you feel much lighter...and it's something totally different. (*Participant K.*)

Hmm, [the Art Therapy] allowed me to sort out my problems without having to say anything. It was a form of release for me. Things that would normally get bottled up. I got to putting it down on paper and know nobody else knows what I was talking about. So it was a safe way for me to do it. [...] If someone else was looking at it, they wouldn't have a clue what it meant. (*Participant N.*)

For one participant (N.), Art Therapy became a problem management strategy. In this way she learned more productive means to release emotions that would

accumulate over time. This way of using art materials was described by the participant like a secret language which kept her safe from the judgement of others. She appreciated having an outlet that was not only safe but could also not be taken the wrong way. Drawing and painting became a symbolic language for things too rude or too painful to describe in words.

Art making is a highly personal and self-directed activity and in that way also offers opportunities for self-empowerment (Merriam, 1998). An important element of the Art Therapy process is to explain one's art work and to verbalise the thoughts and feelings presented in the pieces or those contributing to its creation. As mentioned above, for participants in the current study, art making was in that way used as a form of communication and as a form of release. Through the creation of art work about thoughts and emotions, the processing of experiences was supported. Some participants felt that without Art Therapy emotions would be stuck inside without release or validation.

... it's bringing out so many things, that's pent up, that's inside that I, ... I, don't have the possibility to bring out. It's staying inside. It doesn't matter if you get support, when you have key workers its support, but it's not enough support. (*Participant K.*)

Not only the process of art making but also being allowed to work independently, quietly, without a pre-set structure and with a therapist who supported this working style was different to other therapies. This difference was significant for participants. Although all Art Therapists left the women to choose the themes or topics of each session and supported an independent working style, some used specific means, such as a story or fairly tale read to the women at the

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beginning of each session, to get participants into an inspired and creative frame of mind. Some therapists also started the course of therapy by participating in drawing or painting with participants. The use of a variety of materials from which women could choose as well as the variety of session themes was also mentioned as an interesting part of the therapeutic experience.

It could be a number of things, the reason why you loved it so much, you know... I like the fact that we used different things a lot, paints one week and it would have been nice to do the pottery but that's ok. But every week was completely different. [...] It was the same, but for me, every time I went in there, it felt different, because we were told to do different things. And it'd depend on what happened that week as well so you could have been feeling completely different whether you had bad week, thinking 'Oh, god...' or if you have had a really good week. And you'd go in and you might paint something a bit better, you know, and that depends on your mood as well. (*Participant E.*)

The progression of the single session of Art Therapy was also dependent on outside factors such as the mood of participants or the events of the previous week. As participant E. pointed out, even having a bad week could impact the therapeutic experience.

At the end of each therapy session, women got together to talk about their work as a group. This exchange allowed women to give and receive feedback, and learn from each other as well as their own art work. This process was greatly fostered by the Art Therapist. At that time participants also became aware that drawing and creating art is a form of processing experiences and women were often surprised by how much feeling was released in the process of creating as

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well as through their art work. At times, the emotional response to their own pieces was surprising.

In comparison with other forms of group intervention, Art Therapy consisted of long phases in which participants worked on their own and without conversing. Differently to other therapeutic interventions, the focus in Art Therapy is on the image, which contributes to making this approach a less intrusive and less threatening one for some individuals (Merriam, 1998) and particularly so for female adult survivors of abuse (Brooke, 1995). Some of the elements reported by participants to have made this approach a less threatening one were the relaxation felt during the sessions, the possibility to safely release emotions and the opportunity to work at one's own pace and in silence if participants wished. The silence during therapy was enjoyed by participants as well as the freedom to choose when to talk and when to work quietly. It was clear for participants that even without speaking about specific issues, thoughts and opinions were expressed in a non-verbal manner.

It was nice sometimes to not have to talk. If you didn't want to talk, you didn't have to say anything. But you still express how you felt on paper, whereas in a talking group, you got to go in and you gotta talk. Sometimes you just don't want to, even things that are difficult to talk about you don't want everyone to know, you can still put it down and it will still come out, it still. (*Participant E.*)

Yeah, yes but then its, uh, it's taking a lot off your mind, and you could see it on paper. And talking, no one really talks but then its relaxing as well. And it showed me, it showed us, what we are drawing can't hide. It's very relaxing. (*Participant K.*)

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It has been noted that group work for survivors can be an essential tool in treatment as it helps build connections with others and creates a sense of community that is essential in the healing process (Zust, 2006). Participants in the current study highly valued the group approach and the opportunity to connect with other survivors. Group processes greatly impacted therapy sessions. Being in a group with other survivors drew out issues about domestic violence that had an emotional impact for all participants. Seeing others with similar problems and experiences helped participants reassess themselves, look at their own lives with abuse and reflect other group members' experience. In this way, the experience seemed to contribute to increased self-awareness and to creating a new and differing self-identity. For participants, this identity was particularly important in the move from victim to survivor.

The sharing of experiences as well as their work was clearly expressed by women as a significant element for therapeutic success. According to interviewees, sharing and listening to each other has resulted in feeling "stronger" and in valuing their own strengths. Being part of a group allowed one participant the rare opportunity to talk about domestic violence to other survivors and to look at others' art work. This confrontation helped participants to realise their own strengths.

Not only the opportunity to receive support, but also giving back strength to others, became an important element of healing for participants. The satisfaction of giving help was therefore a large part of the therapeutic experience within the group. The interaction between group members was a significant factor and contributed to gaining personal strengths and confidence. Simply being able to talk about domestic violence to others and having another group member's

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opinion or response to one's art work was helpful in raising the awareness for participants' own personal difficulties. Throughout the process, receiving as well as giving support and encouragement, sharing personal experiences and explaining success stories was extremely valuable for participants and was pointed out numerous times as one of the most crucial factors for therapeutic success.

The group had additional functions for participants however. One participant points out that the group was one of the few reasons she went out of the house despite the difficulties while being depressed. In that way, the group was an important anchor to reality or every day life and part of a crucial social network for survivors. Similarly, being part of a group of women with similar experiences also countered the isolation felt after leaving their partners or families.

Participants also pointed to the emotional impact the art work had on them. The positive effect of art work on people's mood and well-being is well established. For example, viewing art alone has been mentioned to improve the mood of older persons in an inpatient setting (Wikström, Theorell, & Sandström, 1993). The emotional impact of art as well as art making was also explained in a variety of ways by participants in this study. Some participants mentioned a different attachment to art work than to the spoken word. The material used in Art Therapy contributes to the rise of a variety of emotions. In addition, having a record of your feelings as well as the therapy process also enables a different management of problems. The images created in Art Therapy are of central importance as they invite participants to reframe their feelings, respond to their traumatic experiences and work on both emotional and subsequent behavioural

changes (Malchiodi, 2003). To some participants, creating and analysing their own art work became the most beneficial part of the process and was regarded by one participant as an “eye opener” (Participant K.). The participant describes that through the support she has received in therapy and through her own art work she understood the consequences of domestic violence for her. The abuse had left her feeling insecure, and with low self-confidence. With that realisation she also began to understand that she did not deserve to be mistreated, that she was not “a nobody” but a person to be respected.

Art was not only used as a form of expression of emotions and thoughts, art work also created a type of journal or track record of personal processes and achievements during the course of therapy. The availability of a personal record is a further crucial difference between Art Therapy and other forms of therapy based on verbal exchange (Cooper & Milton, 2003). The process of art making and creating lasting pieces of work helped to making long-term achievements visible and enabled participants to compare themselves to other women in the group. Being able to relate one’s own strengths and weaknesses to those of others in the group was said to have been a significant contribution to increased self-esteem. This comparison also enabled women to revisit previous stages of change they have gone through themselves after the experience of domestic violence. In examples brought to explain the individual meaning of Art Therapy, participants often used descriptions of their own art work. The interpretation of art work gave meaning to them and was an opportunity to relate them to every day life. Through the course of ten weeks, women were also able to have a record of their therapeutic change, of important turning points and even thoughts regarding

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specific situations of their lives. The presence of art work was a way to compare feelings and attitudes in the first sessions with those in the last sessions.

Pieces of work created in Art Therapy made it possible to make a problem physical, or give it a form. The creative process and the images become safe transitions spaces where the patient can “be” and cope actively with experiences and feelings (Cooper & Milton, 2003) (p. 168). The emotional weight of a problem, or by participant K. described as the burden, then turns into something more manageable. It is no longer overwhelming but something that fits on a sheet of paper and can be dealt with. What has therefore been described by women as helpful was being able to use art as a way of getting in touch with oneself - and to record this process.

4.3.2 Outcome

Art therapy, and the active engagement with art-making, offers therapeutic opportunities for healthy self-involvement, which in turn can contribute to positive changes in the self concept. As pointed out by Franklin, (1992) metaphorically, there are many similarities between the process of art-making and the process of life. Like in life, participants have to make decisions to transform their art. In that way art “may be considered a simultaneous process of reformulating the self through the active formation of an object” (p.79) and a transformation in Art Therapy may be compared with the stages of human development (Franklin, 1992) . In that way, art-making can resemble growth and can be the source of a great sense of accomplishment. For all participants interviewed, the Art Therapy was a learning experience that brought about a number of changes. The outcome was a positive one for all interviewees. Much

like results of previous Art Therapy research within a variety of populations, the perceived outcome centred around increased self awareness, self-esteem and social skills as well as decreased feelings of depression and anxiety (Green, Wehling, & Talsky, 1987; Gussak, 2006; Kramer Borchers, 1985; Lagorio, 1989; Palmquist, 2003). For some participants, change was subtle and the focus was on only one or two aspects such as small behavioural changes or a change in attitude. For others, the Art Therapy experience brought forth a seemingly dramatic change of life. The various differences in behaviours, emotions and cognitions were often described in detail by interviewees. Women frequently used before and after comparisons in their descriptions of change and in order to illustrate new structures or patterns and described their own art work to exemplify new behaviours or ways of dealing with problems. Also, descriptions of a personal working style during the Art Therapy were used in order to illustrate changes. As mentioned above, art work thereby functioned as a record for the changes made and often contributed to the realisation of importance of these changes.

4.3.2.1. Well-being and Self-discovery

Some women not only reported generally feeling less depressed as a result of the intervention but also mentioned that alternative ways to manage new episodes of depression were discovered. By working creatively and by continuing to make art outside of the therapeutic environment, women found new means of dealing with challenging life events as well as phases of anxiety and depression.

R: So you found your potential through the Art Therapy, is that what you are saying?

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Z. When I say potential to be... I mean in terms of the days when I go dark, I know what to do. (*Participant Z.*)

One participant described a cognitive change as well as a resulting behaviour change as an effect of Art Therapy.

Well, before I wouldn't go anywhere, not even down to the shop. It was difficult for me. But now I can get on the train on my own. Small distances, but I'm getting there. So that's a big change for me. And the fact that... , I had to be where my daughter was. Now I can have my own space and she can have her own space. That's another big change. (*Participant N.*)

The intervention was effective in helping her find ways to deal with anxiety that confined her to the house or refuge before. After the intervention she was able to use public transport, go out alone, and be away from her daughter with out feeling overwhelmed with anxiety.

Self-discovery was mentioned frequently by many participants as a significant effect of the Art Therapy experience. The intervention was described as an opportunity to learn about and to discover oneself anew. To some participants Art Therapy contributed to feeling free and “un-stuck” after the perception of being tied down for a long time. As a result of the Art Therapy participants found new sides of themselves as well as new, or previously hidden, talents.

Yeah, I learned a lot about myself that I didn't realise, although things were happening, and it all came out in my art work. (*Participant E.*)

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I found parts of myself that I didn't know where there. And I've got hidden talents. (*Participant A.*)

Self-discovery often came as a surprise to women. Women were amazed to still become aware of uncovered aspects of their personality (or talents) within themselves. Along with self-discovery, increased self-awareness was also mentioned by all interviewees as an outcome of Art Therapy. Art Therapy became a way for women to re-identify themselves as well as to finding themselves anew.

...I was able to draw, [...] but also through my picture develop a new sense of re-identifying myself. (*Participant Z.*)

Self-awareness and insight was an important factor that translated into every day life. One participant described herself as controlling, rigid and fearful of mistakes before the intervention. After becoming aware of that she tried to change her behaviour in her every day life.

R: And are you like that with other situations in your life too? That you are freer?

A.: I'm doing it now. I wasn't before, I think I was always very planned, um, but now I am more freer because I can see the..., where I was going wrong with this rigidity. You know, worrying about any mistake and learning from my mistakes. And I make them more freely, um, and then sort them out. Reorganise them. (*Participant A.*)

Gaining insight about oneself was also mentioned by participant Z. as one of the most significant effects of the intervention. She now understands herself and her priorities better, such as being in a non-abusive environment. She also gained an

understanding of the impact of past events on her. Most importantly, she has made her personal potential and the ability to reach goals visible to herself.

I don't know if I will ever understand myself to the fullness that we can understand ourselves. But I am...I have an understanding of myself and what I can potentially be... as a person. (*Participant Z.*)

Awareness of personal weaknesses as well as dysfunctional thoughts and behaviours, such as wanting to physically confront others whenever conflict arose, was an important outcome of Art Therapy for another participant. She was able to use this insight to find other ways to deal with similar situations in the future.

In some ways, I've changed a lot. In some situations I can just walk away from, whereas before, I couldn't have stopped. It was always confrontation. Yeah. I am more aware of that now. (*Participant N.*)

4.3.2.2. Feeling "stronger"

When asked in which way women felt they had changed during the course of therapy, many frequently answered that they have 'become stronger'. Strength came up in the interview at numerous times and had various meanings for participants. To one participant, strength meant being able to make decisions on her own, with which she was comfortable. In this way strength was also a synonym for self-confidence, self-esteem as well as assertiveness, which allowed women to trust in themselves.

I think that I've become stronger - myself in making decisions. As I said, I made that positive Art sketchbook, um, and I've used the positive

energies that I had in the Art Therapy sessions, um, and what I've been telling other women, because we've been strength to each other and my experiences were getting stronger and stronger to help other women who weren't in the same place as me. (*Participant A.*)

For participant A., strength was something lasting she took from the course of therapy. To her the sessions meant the availability of positive energy, or a positive attitude, which she could apply to other areas of her life and outside the sessions. Here strength meant the ability to receive support from other women and, most importantly, giving back support and helping other women to recover from the effects of domestic violence. Through the intervention she became aware of her own stages of change as well as the needs of those who might not be at a similar point in the journey as she is.

It's not me, all the other girls that came there, um..., I mean there is one of the girls there, [The Art Therapy] completely made her really strong. Because she could stand up to, to her, her, um, to her boyfriend, whatever. She could stand up to other people. And it just gave her the courage and then she gave it. [...] Its made me, um, I mean, I haven't become strong overnight. But I can see is changed and it's made me stronger. (*Participant K.*)

Strength also meant being able to stand up for oneself, that is, to be assertive and competent to communicate needs and wishes directly. To another participant, strength also meant the possibility of being comfortable alone in a new home. Fear of being found by the abusive partner but also the fear of being lonely often made it difficult for women to settle down in a new space.

I feel I'm a stronger person. And on top of that, now after that I don't need a lot of people. Because when I left, when – I left my house and that, and I came over to the refuge and the... I didn't know anybody. See, then I slowly got to know people, then I said I don't really want people. I just wanted to be on my own and I wanted to sort out myself, sort out my mind. I don't want to be crowded or meet new people. I am going to just pick myself up mentally. (*Participant K.*)

And that group has helped me mature, if you like. And be strong enough to face certain things better. (*Participant K.*)

Participant K. now feels more confident in herself and does not need reassurance from others. By strength she also describes her ability to face and manage difficult situations in the future.

4.3.2.3. Self-worth and Self-confidence

Some women pointed out that art making helped them to feel better about themselves and to gain confidence. The relationship between Art Therapy, and the process of creating, and self-esteem has been intuitively observed by many Art Therapists (Franklin, 1992). The positive influence of art in therapy as a means for expression and development of a sense of empowerment has been outlined and supported in the research of Brooke (1995). In her research with adult survivors of sexual abuse, she found Art Therapy particularly beneficial in gaining self-esteem. The increase in feelings of value, self-esteem and personal worth were also mentioned frequently by interviewees in the current study.

[The Art Therapy] just gave me such confidence as well. The more I would draw the more I would... complain is not the right word. See

things as they would come up. It was just such a release for me, you know, and I felt confident. (*Participant N.*)

My confidence scale has moved up a peg. I wouldn't say it's full at all but it's moved up a peg. I still have a long way to go but it has made moved up and I have come from a long journey and I don't expect my journey to be cut short. But it's falling into place quick. (*Participant Z.*)

R: So you feel like you are more confident in yourself?

Yeah. Yeah, yeah. I think the art actually was something I was very prohibited by, having a part with the artist and just thought 'no, no, this is rubbish'. I actually let myself go with it and it wasn't a case of 'oh, it's got to look really arty like a famous artist. (*Participant A.*)

For some participants, the prospect of having to be creative however, contributed to more intense feelings of insecurity and low self-confidence before the start of the intervention. During the ten weeks however, these feelings changed for all women. Gaining the confidence to draw and paint even if the result was not a perfect work of art but rather enjoying the process of art making was important. Letting go of the expectation to create something perfect also made women more confident in their individual (artistic) abilities. Confidence was in fact gained by being able to produce art work. This development was an important one, since the aesthetic value of the art work is not the main part of Art Therapy (Ulman, 2001). Being in the flow of creating rather than letting herself be prohibited or scared by it was part of the process of Art Therapy mentioned by one participant (*Participant A.*).

So I value myself more, whereas before, I didn't. Well, a little bit, but not as much. At first, I thought I was quite creative with my work when I look back 'Yeah, you can do this, this is gonna work'. So that was quite good. It was quite a confidence boost, looking back.

(Participant E.)

Seeing themselves as valuable individuals who deserve to be treated in a respectful way was one of the more frequently mentioned cognitive changes. During the course of Art Therapy, women also saw that being able to create something and being able to be creative was a confidence boost after the emotionally damaging experience of violence from an intimate partner. The empowering impact of art-making to enhance self-esteem, one of the most important goals in the therapeutic intervention with survivors of intimate partner violence, has also been mentioned by Franklin (1992). According to Franklin, the opportunity for participants to create their own images and participate in their unfolding is an important contributor to the therapeutic theme of empowerment (Franklin, 1992).

4.3.2.4. Empowerment and Assertiveness

In line with self-confidence, women also talk about having become more assertive after therapy. The discussions as well as the opportunity to work through experiences in their abusive relationships might have contributed to understanding the danger as well as the injustice done to them in the past. One participant saw herself empowered and more assertive.

The problem with me is I'm always being like,... I let people walk all over me. People can say things and do things to me... I will just be quiet.

But now, But now, now I'll stand my ground. I stand up for myself. I won't let that happen anymore because I thought "No". Because you know, uh, that group has told me, and through [the therapist] as well, that I can't just let people walk on top of me. Its time to change!

(Participant K.)

She realised through the group and with the help of the therapist that she has rights worth reinforcing and that she does not need others to walk "on top of her". Feeling more confident and assertive made one participant re-gain control of her house, which her brother and friends had taken over. With the support of the group as well as the Art Therapist the participant in this particular example found the courage to make him leave.

And I can actually say 'you know, I don't really want to do that', whereas before I'd just go 'oh, ok.' Just to keep everyone happy, and now I know you can't keep everyone happy. You have to try and make yourself happy too. *(Participant E.)*

By realising the impossibility of making everyone happy at the sacrifice of own personal needs she was able to refocus her attention to the responsibility for herself and her personal well-being after the intervention.

Increased self-awareness, confidence and assertiveness might have significantly contributed to changes in behaviour, such as becoming more talkative, beginning volunteer work or actively facing ones fears. As mentioned previously, participant N. described a cognitive change as well as a resulting behaviour change as an effect of Art Therapy.

Well, before I wouldn't go anywhere, not even down to the shop. It was difficult for me. But now I can get on the train on my own. Small distances, but I'm getting there. So that's a big change for me. And the fact that... , I had to be where my daughter was. Now I can have my own space and she can have her own space. That's another big change. (*Participant N.*)

4.3.2.5. Understanding Others

The promotion of social skills is an often mentioned effect of group Art Therapy (Green et al., 1987; Kramer Borchers, 1985). Understanding and getting along better with others was also mentioned by participants in the current study. One participant noticed that she approached people in a different way after therapy. She recognised that she had judged, and misjudged, individuals too quickly before. Seeing people in a different light, and giving them a chance by getting to know them better, were effects of therapy acknowledged by this participant.

It's made me think twice about people, not to judge people too quickly. [...] ...because you meet people, you know. When you go to the course we were all on equal footing and then you go, you teach, you can talk about your problems and I discovered that you can't just look at somebody, like you mustn't judge a book by its cover. So you look what's happening and say 'Oh yeah, they not too nice, they're not too friendly, they're bit sharp or whatever but its taught me something, to see things. They can't talk really. It's taught me that you have to try and you know and can't judge too quickly. Because a lot of them have a lot of problems like yourself. (*Participant K.*)

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The therapeutic environment for example was said to bring group members, i.e. women within the refuge, closer together. The positive group dynamic helped to counteract the isolation many survivors feel after leaving their families.

[The other group member] and I got along great. In fact, [the Art Therapy] brought us closer. Before we'd only talk if we met in the kitchen or in the bathroom but afterwards we even talked when everyone was outside. It feels really good. (*Participant N.*)

Similarly, women found the creativity brought out during the intervention was beneficial when trying to connect to others. For one participant, art making was also a way to connect with her younger daughter. In this way, Art Therapy offered a new avenue to reach out to one's children and re-connect - an important factor in mother-daughter relationships after the experience of domestic violence (Hass, 2003).

I did a picture for my youngest daughter. And I told her what I've been doing. She says 'Show me the picture of how you feel when we go home Mummy'. She is such a mummy's girl.

R: That's a good way to connect actually, having the art.
For my little girl especially... (*Participant N.*)

4.3.3. Therapeutic Elements

In all interviews participants discussed in great detail the therapeutic elements that made the intervention helpful and beneficial to them. The therapeutic relationship, feeling understood as well as respected by the therapist, was a significant factor in treatment for all interviewees. The opportunity to share experiences with peers was also mentioned as a significant therapeutic element

much like the ability to increase self-awareness. Further curative factors of groups as outlined by Waller (1993), including in particular the giving and sharing of information, interpersonal helping and learning, the discovery that others have similar problems and anxieties, as well as the opportunity for catharsis, were important elements for women in the group (Waller, 1993).

4.3.3.1. Therapeutic Environment

Two further significant factors were the existence of a safe and positive therapeutic environment and helpful discussions between group members, which were greatly encouraged and fostered by the Art Therapist. As outlined by Rogers (1951) the presence of six basic conditions is necessary for change in therapy. Two individuals (a client in a state of incongruence and a therapist integrated and congruent in the relationship) in psychological contact, unconditional positive regard from the therapist toward the client, empathic understanding towards the client's internal frame of reference, and the communication of empathic understanding and unconditional positive regard is achieved (Rogers, 1951, 1992). In general, participants in this study reported to perceive the therapeutic relationship as such. In addition, women valued a relaxed and secure atmosphere and a safe environment. To participants, a safe therapeutic environment was not only one in which they felt physically safe but a therapeutic environment was also a relaxed and non-intrusive one in which women did not fear being judged, criticised or ridiculed. A crucial part of a good therapeutic environment was also a positive relationship between group members and therapists.

Uh, it was such a relaxed atmosphere. I felt safe and um, able to express myself without anyone criticising me. I don't know, I just didn't feel like

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everyone was watching me or judging about what I put down on paper.
(*Participant N.*)

Similarly, what made the sessions significant for some participants was the availability of support. Participants described the emotional support of peers as well as that of the Art Therapist as a significant factor, which made them feel stronger (i.e. more confident and self-efficacious). This became particularly apparent as the weekly sessions came to an end and participants no longer had the support they had become used to.

But, um, if I would still have the sessions, the Art Therapy sessions a week I would be getting stronger again 'cause that's when I felt my strongest. By the time I'd finished I felt like a really strong person and now I can feel myself... but maybe because I have no support there.
(*Participant E.*)

The therapeutic relationship has been mentioned by all participants as one of the most crucial parts in their experience. Because the relationship to the group and most of all to the therapist was frequently mentioned by participants in all interviews, it is given particular attention. Numerous articles outlining the importance of the therapeutic alliance (the bond and collaboration between therapist and client) already exist ((Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2009; Martin, Garske, & Davis, 2000) and it is well established that a good therapeutic alliance between therapists and clients at any stage of treatment may be therapeutic in and of itself (Martin et al., 2000). Many studies as well as anecdotal evidence suggests a strong positive relationship between the therapeutic alliance, or good rapport, and treatment outcome is said to influence a client's

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decision to remain in treatment (Odell-Miller et al., 2006). All women interviewed discussed the impact the Art Therapist had throughout the intervention.

Participants reported to have enjoyed a positive therapeutic relationship throughout their experience and were acutely aware of the importance of such a connection. Most women had a concrete idea of aspects that should be in place to create a therapeutic atmosphere including a friendly and relaxed atmosphere, a non-critical stance of the Art Therapist, positive regard, professionalism and the perception of being validated.

Although information about Art Therapy was given beforehand, many participants expected a school-like atmosphere, in which the Art Therapist would act as an art teacher. Therapists were frequently referred to as teachers or “the person sitting in”. In that way, women seemed to confuse Art Therapy with art education and were surprised, but pleased, about the unexpected and at times somewhat passive role of the Art Therapist.

Um, yeah, [the Art Therapist] guided very well. I first thought there'd be a lot more input, that she was sort of, um, be more like telling you what to do and how to do it, but she left it open for us to actually do this ourselves, which is very important I think and I like because I've always [been independent]. (*Participant A.*)

So I didn't feel like she'd [the Art Therapist] say “Oh come on, you gotta do this. We only have ten weeks, we got to get there” All this was happening... It wasn't like that..... It was good though. I did really enjoy it. (*Participant E.*)

Women very much enjoyed the friendly and relaxed atmosphere created by the therapist in Art Therapy. They also appreciated the independent working style and

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openness of the therapist towards the group's wishes. All participants interviewed concluded that the Art Therapist played the most central role in their therapy experience. Women with some familiarity with therapy in the past were comparing the Art Therapist to previous therapists they had encountered. All therapists were perceived to be equal to or better than previously encountered therapists.

[The availability of the art therapist] did [make a difference], yeah. Um, she was so understanding! She did not push us to do anything we didn't want to do. If we wanted to draw, we could have to draw. If we wanted to talk, we could talk. It's very relaxed and very, very nice. (*Participant N.*)

Before I had therapists which I had the feeling were putting something on me, they expected something of me. [The Art Therapist] didn't expect anything, um, didn't expect anything of me. First me being and doing what was coming from me naturally um, and she is very understanding how she listened, which was a lot of talking of other people's emotions coming up and she listened and never dictate or sort of, push suggestions if you like, which gave more [support] in this way, in a good way. She was very nice and friendly and I felt comfortable with her actually. People in the group as much as myself felt comfortable and you could say anything to her and feel secure. (*Participant A.*)

Participant A. appreciated the gentle guidance rather than the rigid structure that she had experienced before and had expected again. Participants perceived that the Art Therapist took a neutral and rather passive role when it came to the creation of art work by participants.

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To interviewed women, a good therapist was one that was friendly, understanding and supported the innate ability of art making as well as the independence of group members. The projection of security and honesty was also an important aspect that fostered a positive and productive therapeutic atmosphere. This atmosphere and the important role the therapist played in that were mentioned frequently in several interviews. Women also frequently mentioned the importance of feeling validated and of not being judged or criticised by the Art Therapist.

I would have felt that [the Art Therapist] was judging me and I never once felt being judged. I could say things without being judged. So yeah, very important not to be judged and that they are not going to tell someone else what you speak about. (*Participant A.*)

The opinion of the therapist was highly valued and respected. Some participants conclude that change, or feeling better, was only possible because of conversations with the Art Therapist. Feeling accepted and understood was therefore key in the therapeutic relationship for all women interviewed. To most participants, the Art Therapist is of central importance for the outcome of therapy.

I have turned it completely around by the time I'd finished the course. And it was down to the Art Therapy, it was because of what [the Art Therapist] was saying to me and made me realise things. (*Participant E.*)

I think the teacher makes all the difference. Because the teacher she could know her stuff but its how she comes over... . And she, she is very polite but she, she is very sincere. And she's got a lot of patience and anything is not a problem. And she says: put anything in, if you feel

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yourself ending just stop. And, uh, its amazing how you, you would...
but you can go, it can get quite intense, you wouldn't believe it.
(Participant K.)

To this participant, the work experience and professional knowledge of the therapist is even less important than the therapeutic relationship she is able to create, that is how she works with the clients and presents herself.

All interviewees in this sample reported a very positive and close relationship with their Art Therapist. Gratitude was often expressed towards her and many women complimented the therapist numerous times during the interview. Interestingly, many women discussed the many roles the therapist took on within the therapeutic context: that of a supporter, mediator, teacher, friend and, at times, advisor. Art Therapists played a crucial role in the meaning making of women's art work. Many interviewees referred to the Art Therapist as a "translator" for their work - a mediator between the creator and the created art, who helped participants make sense of their work and, most importantly, helped make this meaning applicable to the participant's life. Frequently there was amazement about the results of the participant's creative input as well as the interpretation thereof. Women did not expect their own art work (and their interpretations of them) to be so revealing of their personal issues. Women used both, the revealing quality of art making and the interpretations from the therapist, for their self-exploration.

But this time, its taking... , and she is on top of that, she is translating and she is saying to you, 'Well you drawing this, um, it means this, it means that, what did you have in mind when you draw this?'
(Participant K.)

And obviously [the art therapist] could see that [how I felt] in my work. So, and she'd say this is because this and this is because of that, you know, like: "People are taking advantage of you, why are you letting them take advantage of you?" And it all came out in my work.
(*Participant E.*)

The Art Therapist also played a significant part in adding a new perspective to the women's situations. By asking about the meaning of participants' art work she showed interest and also brought the women to question their work. It seemed that the questions asked by the therapists played an important part in sparking an interest in women's art work, in opening the door to interpretation and in helping the women increase their self-awareness as well as their perceived self-efficacy.

And I got [the Art Therapist] to help me do this... And 'What's your picture about?' 'What's your significance?' and to elaborate. So I think, it's like actually doing that kind of pattern again..., whereas before when you do go through that trauma, you do live in isolation, become silent. And even if people do want to talk to you, you do talk but you don't really talk as much. So this is what this group, through the Art Therapy has done. (*Participant Z.*)

One participant also saw a role model in her therapist. She reported that group members were able to identify with the art therapist who had disclosed difficulties in regard to setting boundaries, and being able to say no. The shared story and self-disclosure of the therapist functioned as an inspiration for participants. As a role model, the therapist also modelled new behaviours that women found helpful and encouraging.

She [the art therapist] is a really strong character. She is, yeah. She said she used to be like... me and all the others, where they'd like... you know, feeling awkward to say no. And she said she used to be like that. [S: so she was like a role model then, wasn't she?] Yeah, yeah! Because I sat there and I think: Well if you can do that then so can we. Yeah. But yeah, 'you've done it and you have no man in your life, controlling you, telling you what to do and things like that'. [...] And she never said anything in hurtful way, it was in such a nice way but in a really strong voice, kept quite low. Not raised or anything. Whereas me... I just go mad. (laughs). I don't know, she just kept her posture and repeated the same thing. Like 'I would like you to leave. I would like you to leave'. It's just amazing. (*Participant E.*)

Therapists were also key when it came to instilling new confidence in women. By being patient as well as appreciative of women's art work, participants were able to see the value of their work themselves. For many participants, the art therapist became a central form of support. This was particularly important as many survivors did not feel that they had enough support in their situation.

4.3.3.2. Opportunities for Self-awareness

The word 'surprise' in regard to the therapeutic experience and the outcome is mentioned frequently in all interviews. Women often seemed surprised by their ability to work creatively in this way. Having that experience, including the surprise, greatly contributed to feelings of pride and consequently confidence.

I learned a lot about myself that I didn't realise, although things were happening and it all came out in my art work. [...] Yeah, sometimes I thought 'Oh, why have I done that' and then you look and people... with

the other peoples opinions you could really see. [...] Its amazing that you can look at my picture, tell what's going on in my head, like sort of thing, you know? (*Participant E.*)

Meaning to personal art work would be given by the women later on or through the discussion and the help of other group members and the therapist. The Art Therapist's "translations" of art work, i.e. offering possible interpretations and helping to give meaning, was one of the most significant therapeutic elements of Art Therapy for several participants.

...and some things happened over the weekend, you know, and we're coming and [the therapist] said 'Oh, how are you?' and you go 'oh I'm fine' and whatever. And then you come... 'Oh no no, what's the matter? And you could feel you could open up...' and we all opened up. Because we feel secure, we feel confident and that. And, umm, when you come and you draw she said "do that and you know its gonna come". And then she will translate it... its good that at least it's come out and you feel lighter, don't you? (*Participant K.*)

4.3.3.3. Learning new Behaviours

The art making process enabled participants to learn and practice new behaviours within the therapeutic environment. In previous research, Franklin (1992) has already noted that the therapeutic atmosphere, as well as the art work itself, can become a safe place where the old thoughts, feelings and behaviours can be confronted and new ones can be rehearsed (Franklin, 1992). Similarly, As Malchiodi (2003) points out "art making allows an individual to actively try out, experiment with, or rehearse a desired change [...] that is, it involves a tangible object that can be physically altered" (p.19). The changing of old behaviour

patterns and the rehearsing of new ones within the safe therapeutic space has been mentioned frequently by participants. One participant describes her change from being timid, rigid and controlled to free and less worried. This behaviour has generalised from the therapeutic environment to her life at home. Although she is talking about her art work in this example, it is reminiscent of her life and her journey through domestic violence.

I started with coloured pencils, very.... 'oh I can't draw', being very inhibited, on smallest paper, ended up on putting everything together on the whole table. They got bigger and bigger as the weeks went on, um, and more confident, that way I was using the brush, very artistically, if you like, with the brush more. Whereas before I was very precise and rubbing out, I didn't use rubbers, I stopped myself, said 'ok, I've done it, I paint over it, that's it'. And I learned to be um, not controlled... It taught me lots of things about control as well and about being free, not worrying so much about mistakes. That's the one thing, I am very sort of, um, a person if I've done it wrong, I rub it out, even with my cooking, even with my... it take me... it makes me so free. I was quite surprised 'oh look at me, I'm doing it in any old how and I am not worried about the end result'. I was happy with the end result...
(Participant A.)

She also comments on how much freer she is able to paint after a while in comparison to the beginning when her work was negative and deeply emotional. In the process of painting, a lot of feeling, in her case anger, was released. The opportunity to release anger in a constructive way was also mentioned frequently by other participants.

It has been noted, and used effectively in Art Therapy with other populations, that artistic expression of emotions can serve as a coping mechanism, which can be

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used to decrease aggression and destructive impulses (Smeijsters & Cleven, 2006). For some women in the current study art making became a safe, non-verbal strategy to release and manage negative emotions, such as frustration, before they would build up or become uncontrollable. Art materials can be used symbolically in the communication of experiences and feelings, which can also be useful in developing coping mechanisms. By creating, participants have been able to neutralise feelings and the propensity for aggressively or destructively acting out these feelings. By doing that, art can help in not letting aggressive feelings become overwhelming (Cooper & Milton, 2003). In that way, art also became a means for managing different types of daily issues from decision making to anger management. As mentioned previously, participant N. felt better equipped to handle her routine and every day problems after the experience of Art Therapy.

Two participants mentioned that Art Therapy has had an impact on their parenting. Because the intervention was an important way to relieve frustration, it functioned as a form of stress management for them, which in turn fostered calmer reactions towards the children.

And the thing is, its making you a better person so you can deal with your children and issues outside in a better way. And in the long run.
(*Participant K.*)

And it turns out how it's helped today with my parenting. I have two boys, there are certain things in school... And I talk about things in my school. (*Participant Z.*)

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4.3.3.4. Time for Self and Relaxation

Despite Art Therapy being hard work on one hand, simply having the opportunity to take time for themselves, do something that they found relaxing and enjoyable, was mentioned by several women as a further important aspect of the experience. Art therapy has been reported to provide opportunities for to self-heal and self-soothe (Malchiodi, 2003), particularly for survivors of abuse (Estep, 1995). In the literature, art making was referred to as a functional way to express feelings and to satisfy women's needs by doing art for themselves rather than for someone else (Stokrocki et al., 2004). For many participants, simply having the opportunity to satisfy their own needs, to relax and to have time for themselves, in which they are allowed to only focus on themselves, was unusual and highly valued. Time to themselves was rare, particularly for mothers and while living in a refuge. One woman reported never having taken the time for herself or for experimenting with new skills while she was in the abusive relationship. In a way, the art therapy gave her the rare chance and possibly an excuse to take time for herself.

I think [the art therapy] is good as well and you are relaxing as well. You know what happens, a lot of us got children and we don't get time to ourselves. So you are relaxing, you are doing something, and its hard work as well...because the time you are spending there, concentrating full time and then it's something totally different. It's something just for you. (*Participant K.*)

Um, I am a mother of two children, that calls for a lot. Art Therapy offers me time for myself and I enjoyed it. (*Participant Z.*)

[Time for myself] is something I'd never done before. I have never considered anything like it. Um, I was always so concerned about what other people were doing. So to have that time for me, um, it turns out, not caring about anything going around me. It's great! I loved it.

(Participant N.)

Having and using time for themselves was a new experience for other participants as well. One participant describes how she was too concerned about what others were doing instead of allowing herself personal time.

The relaxing and soothing effect of art making was also mentioned by women. The relaxing effect of Art Therapy played an important role for participants in previous studies (Green et al., 1987). In line with these findings, Malchiodi (2003) has pointed out that that art therapy can be used to “tap the body’s relaxation response” (p.21). Observation and anecdotal evidence suggests that the creation of art has a soothing and relaxing influence on individuals, particularly those who are anxious or suffer from post-traumatic stress (Malchiodi, 2003).

4.3.4. Implications

Although the personal experiences of domestic violence were not discussed as part of the interview, the women’s past inevitably came up in some interviews. Women had frequently left in fear and found themselves in a refuge without support, low self-esteem or perceived self-efficacy after leaving the abusive partner. Most often a wish for help, such as more support than regular routine intervention, was disclosed. Personal experiences with violence within the home were also used to further explain the importance of the therapeutic intervention for them. Participants also understood that the readiness for change is

important and that a therapeutic intervention of this kind is not effective unless the time is right for it.

So this group has made me think. The course made me think. Because even though you are told you have to be strong and I have to do that, it doesn't happen unless the time is right... (*Participant K.*)

Women interviewed felt quite strongly about the changes they have made during the course of therapy. Evidence for effective changes was the continuation of the changed behaviour even weeks after the intervention had come to an end. One participant in particular refers to this evidence of change by describing her maintenance of strength, the maintenance of a personally new and positive outlook.

Um, yeah I think it has changed me because I'm sticking to it. I still haven't gone back, I haven't gone back to weakness, which I have done often in the past. I still have that strength. [...] And this type of woman and where I was at, um, it's kind of kept me where I want to be and I can do it and I'm quite happy with doing it and quite comfortable.
(*Participant A.*)

Participants no longer wanted to be victims but rather felt that they can now maintain the non-victim status as a result of the Art Therapy experience. The outlook to the future was a positive one for all participants interviewed.

Most importantly, all participants who had been interviewed agreed that Art Therapy was a useful and beneficial method for survivors of domestic violence. Because the basic trust has been violated for survivors of intimate partner violence, the use of art within a therapeutic setting is thought to offer a

less threatening means of communication (Bass-Feld, 1994) and to build self-esteem and confidence that often lacks after the experience of abuse. Many women also suggested this form of therapy should be available not only to all survivors but also to all populations in need of therapeutic intervention. While being in a refuge, therapy for survivors seems most beneficial as women have begun to institute change at that point and help for the negative effects of domestic violence is often urgently needed (D. M. Johnson & Zlotnick, 2009). Participants who were able to attend therapy within the refuge were grateful for this opportunity. Because survivors of domestic violence experience controlling behaviour from their partners and frequently have only restricted/limited freedom and access to outside resources, a therapeutic intervention for survivors still in abusive relationships is rarely possible. An abusive partner might not allow regular therapy attendance and responsibilities at home might be given priority. The intervention within the refuge with residents is a good alternative because even after separation, many survivors in refuges live in fear of being found by their partners when going out of the house. All interviewed women who participated in Art Therapy still felt vulnerable, indicating that this is also a crucial time to offer support in the form of therapy.

4.3.4.1. Suggestions for Change

Suggestions to improve the intervention with survivors in the future were also made. These suggestions centred around the length of therapy, consistency and the group size. One of the most discussed issues was the time or therapy hours received. All interviewees mentioned that a course of 10 weeks of Art Therapy was not enough. In their view, ten weekly sessions meant only the beginning of a journey that takes much longer. Women not only said that the ten

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weeks were insufficient, but also that individual sessions should be longer than 90 minutes. Many participants felt that they had begun working intensely only at the end of the course, shortly before sessions came to a close. The wish for further self-exploration was expressed frequently.

I'd make it longer. (laughs) I'd make it longer and more intensive. Maybe another hour. Definitely another hour, um, but everything else, the tea- , the tutor [Art Therapist] great, um, the information leading up to it great, so that would be it really, more time. (*Participant A.*)

I do think that ten weeks wasn't long. [...] Maybe a few, I don't know how many, but a few more weeks on top of that. 16 weeks, 20 weeks... but only 10 weeks....Well, I prefer 20 weeks. But even if [the Art Therapist] was to do... I don't know, because of the time. It could be one on one off, or more short courses or a longer course. (*Participant Z.*)

No, I don't think [ten weeks] is enough, it was quite intense at the end and I wish we had carried on because there is probably a lot more... that could have come out then. [R: Like what?] I don't know. You know... maybe we could have done it all a bit slower. And it could have gone into more depths about feelings, you know? Just gone into things without feeling rushed. Do you know what I mean? 'Cause it was like 'we only got ten weeks, we only got ten weeks, it's gonna fly by'. (*Participant K.*)

Women expressed the wish for more time to maintain and build on the changes they have made. Although ten weeks had seemed a very long time at the onset of the intervention, women wished that they could have had more time for individual sessions and topics without feeling rushed. Participants also communicated that they realised the value of Art Therapy in their lives more once the sessions had

come to a close. One woman felt that the end of therapy cut her road to self discovery short.

[If it was longer] You could get a lot more done, um, you could find yourself even deeper. It could be, um, expanded, um. I felt that if I did have Art Therapy, which I quite like to do, um, over a period of time, I'd find out a lot more that's hidden in there than I think I have expressed in those short ten weeks. [...] It looks like I've come a long way in such a short space of time. It's shown me that... doing this for a longer period would be... can make a tremendous difference to my... my life I suppose. (*Participant A.*)

For many women, the end of the therapy also meant the end of many other positive aspects. The weekly group was missed by participants and it had become part of their routine to which they looked forward and to which most participants were very committed.

But now there are situations where I haven't gotten that release anymore. It's gotta come back somewhere. (*Participant N.*)

Along with a wish for a longer and more intense course of Art Therapy, one participant also discussed the meaning of losing Art Therapy in detail. Despite her great perceived therapeutic success, she felt that losing the weekly therapy group was a deciding factor in her feeling worse again. The Art Therapy session as one set appointment weekly was a starting point for organising and structuring her daily life as well as her family better. The end of the weekly sessions also brought back feelings of depression. During the Art Therapy she had

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support to ‘move forward’, she reported feeling held up and generally happier.

Without the Art Therapy she feels stuck.

And I seemed to have moved forward quite a bit but now, now that it’s finished I can feel myself going back a bit. [...] But, um, if I would still have the sessions, the Art Therapy sessions a week I would be getting stronger again ‘cause that’s when I felt my strongest. By the time I’d finished I felt like a really strong person and now I can feel myself... but maybe because I have no support there. [...] It was such a big part of my life at the time. Even when my son was sick, he had the chicken pox, I left him with somebody else just to go there. I couldn’t concentrate too well but I didn’t want to miss it. (*Participant E.*)

Another suggestion for the future included the group size. Group size varied between 2 and 7 women and drop out was a significant factor for the size of many groups, particularly in smaller refuges. Although the intimate setting had some advantages, one woman felt that seeing the art work of more women, sharing more experiences and receiving more feedback could have been of greater benefit.

The need for consistency was another point women expressed. Although having to improvise was an unfortunate aspect of the research project, its disadvantages were pointed out by participants.

I didn’t like the setting. Because it was, um, the tables and chairs were too low. The children’s playroom, I didn’t like that at all. We all thought it was going to be held up here [the common room/living room in the refuge]. Then it wasn’t, it was uncomfortable. (*Participant N.*)

4.3.5. Conclusion

As mentioned by several researchers in the past, recovery from domestic violence is not an easy journey for survivors and women can be thrown by different phases they may experience in the process. Treatment should always be appropriate for the stage of recovery (Smith, 2003). All women in this study had left the abusive relationship and were in the process of rebuilding their lives independently. This fact is important in considering the responses given by participants in the interviews. The amount of helpful information given by women about their experience with Art Therapy is nonetheless crucial for the further exploration of the effectiveness as well as efficacy of this intervention with survivors of domestic violence. From the qualitative analysis, it can be concluded that participants appreciated this form of therapeutic intervention and were able to articulate this value to the researcher. All interviewed participants perceived and experienced the Art Therapy group as supportive as well as curative in its effects. Participants felt that the intervention has particularly helped them in gaining self-esteem, assertiveness and confidence. Particularly the participation in art making, thereby focusing on accomplishments, abilities and one's personal uniqueness, as well as sharing the process with other group members seemed to elevate self-esteem. This increase in self-esteem may have had an impact on a more positive perception of the individual situation as well as the future.

Recovery from IPV does not take place in isolation but within the context of relationships (Smith, 2003). The support from both the therapist, as well as other group members had a significant impact on women's well-being. It became clear that the opportunity for therapy was meaningful for participants in a number of ways. For some it was a way to get out of the house, to meet other women and

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be social, but also to learn and discover new things about themselves. For others, Art Therapy presented time for themselves or became the point of personal strength and support. The experience of Art Therapy was also the start for new ways of managing life and nourishing themselves. For many of the women who participated, Art Therapy brought out a creativity that has outlasted the course of therapy. One woman reported setting Art Therapy days aside as days for herself as well as her creativity in order to continue her own journey of self-discovery. The intervention was also the spark of new creative projects to help one woman outside of the therapeutic environment. Most women interviewed reported to still use the medium of art as a strategy for managing life events and to make them feel good, even after the end of the intervention. The benefits of creativity therefore have outlasted the art therapy course for many participants.

In summary, interviewed participants support the outcomes of statistical analyses and confirm the value of Art Therapy as a beneficial intervention for survivors of IPV.

CHAPTER 5 DISCUSSION

5.1. Review of quantitative results

5.1.1. Dependent Variables

The main questions addressed in the quantitative part of the investigation were directed at a) whether women who receive either therapeutic intervention (i.e. Art Therapy or Person-Centred Therapy) improve in psychological well-being in comparison to women in a control condition, b) whether group Art Therapy generates similar results to group therapy from the Person-Centred perspective and finally c) whether any changes in well-being are maintained after 10 weeks. It was hypothesized that women in both therapeutic groups will report a greater increase in psychological well-being than women in the control condition who received routine care without additional therapeutic intervention. In addition, it was assumed that results would differ with respect to therapeutic approach, i.e. Art Therapy and Person-Centred Therapy. Based on previous literature and due to the unique opportunity for expression and successful application of Art Therapy with other survivors of trauma, (Brooke, 1995; Cooper & Milton, 2003; Laub & Podell, 1995) we hypothesised that Art Therapy will significantly differ in its contribution to an increase in positive treatment outcomes, such as the increase in psychological well-being.

The sample of participants contributing to the current study was representative of the population of survivors in general. The average age group of participants was 33-37 years old. The largest percentage of participants (62%) was between 23 and 37 years old. In accord with present research, young women are more likely to seek help from refuges after experiencing IPV (Edelson, 2000; Rennison et al., 2000; Wilt & Olson, 1996). The majority of women who

participated in this study reported having at least an A-level (or GCSE level) degree but might not have worked in jobs appropriate for their level of education. It is not clear whether the experience of domestic violence is in some way related to a woman's choice (or opportunity) of occupation. This finding supports many professionals' opinion that domestic violence can occur at all socio economic levels (Ganley, 1995; Koss & Hoffman, 2000). Poverty however, has been identified as a key contributor to IPV (Jewkes, 2002). A large percentage of mothers in the participant's family of origin were not working in well paid positions (many relied on benefits), the majority of fathers however, occupied higher professional roles. All women in the current sample had separated from their partners and were not living with them at the time of the study. Women reported a wide range of times since separation, from just a few days to over 12 months, for various reasons. Survivors who had only recently moved into a refuge were less likely than those who have been there for several weeks to take part in a study or in therapy. Some women had spent some time to move refuges after being found before taking part. Similarly, some women had spent some time with friends and family after separation before deciding to live in a refuge. Because women were also recruited through agencies working with survivors, a small number of participants had already left a refuge shortly before taking part in the study.

The data collected from survivors of IPV in this study clearly show the relationship between the experience of violence and mental ill-health (Campbell, 2000; Ehrensaft, 2007; Golding, 1999; Humphreys et al., 2001). The data collected at baseline indicate a rather high psychopathology for participants compared to the general population. For example, a large number of women

reported particularly high levels of symptoms of PTSD including intrusion, dissociation and avoidance. Twenty seven percent of participants suffered moderate depression, an even larger number, thirty nine percent, reported symptoms of severe depression. These are alarming numbers, particularly in comparison to depression rates in the general population, which range between 8 and twelve percent (Singleton, Bumpstead, O'Brian, Lee, & Meltzer, 2000). In addition, a large number of participants report very low self-esteem. These findings reflect the problems discussed in numerous research articles outlining the correlation between women's experience of domestic violence and mental ill health.

In addition to symptoms of PTSD and overall psychological well-being (global severity), depression and self-esteem were of specific interest in this study, as these aspects have been reported consistently to be associated with the experience of domestic violence throughout the literature of the past two decades (Arias & Pape, 1999; Humphreys & Thiara, 2003; Kelly 2004). During the course of the study, all participants' well-being tended to improve regardless of the intervention group. This finding indicates not only that therapeutic intervention is an important factor in the healing process for survivors of domestic violence, but also that routine interventions provided by refuges (i.e. as experienced by the control group) play a valuable and important role in helping women recover from their experiences. Nevertheless, as the present study design did not include a group neither receiving therapeutic help nor routine care, this assumption can not be verified and, therefore, remains to be investigated in future studies. Reports, statistics and anecdotal evidence provided by refuges however, suggest that the support given in refuges can be crucial and at times life saving for women

(Frauenhaus Greiz, 2004, Wandsworth, 2005). Despite the general improvement of psychological well-being in the entire sample, some differences exist between conditions. Therapeutic interventions, specifically Art Therapy, contributed to a much greater and quicker recovery on several scales than routine intervention in refuges alone. These findings are summarised below.

5.1.1.1. Perceived Self-efficacy

Women in this sample had a rather high perception of self-efficacy. The reason for this finding might have been the fact that all of the participants had already taken the important step of separating from their partners and had started the process of rebuilding their lives. Although the measure of self-efficacy was included originally as a predictor variable, the significant change in scores is worth mentioning as an important finding in the analysis. The Friedman's test points to a significant change in scores between baseline and end-of-treatment measure only for women who had attended Art Therapy. Although self-efficacy did not further improve once therapy had ended for these participants but the achieved level was maintained ten weeks later. This indicates that although this measure could be seen as a relatively stable personal trait, the perception of general self-efficacy can be significantly improved by a therapeutic intervention such as Art Therapy.

5.1.1.2. Self-esteem

Almost half of all participants reported very low self-esteem at the beginning of the study and women in all three intervention groups reported greater self-esteem ten and twenty weeks later. At the end of the study, 22% of those

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women who had completed the study reported low self-esteem. Although there was no difference in scores between the groups at follow-up after five months, there was a difference in the rate at which groups changed over the observation period. A difference exists in the rate of improvement between the scores of women who received therapy and those who did not receive therapy in addition to their routine intervention. In the Art Therapy condition 37 percent of participants reported considerably low self-esteem at baseline. After the intervention only 20 percent of women reported a self-esteem score of 15 or below. After 20 weeks, reports of low self-esteem had increased slightly to 28.6 percent, which is still significantly lower compared to baseline. Attendees of Person-Centred Therapy reported low self-esteem at a much higher frequency. In this condition, 71.4 percent of participants reported low self-esteem at baseline. After therapy this number dropped to 50 percent and after 20 weeks the number of women experiencing low self-esteem decreased again to 22 percent. Thirty nine percent of women who did not receive therapy in addition to routine intervention (women in the control group) reported low self-esteem at baseline. At the end-of-treatment measurement at ten weeks, twenty-three percent of women still reported low self-esteem whereas only 14 percent of participants suffered from low self-esteem after 20 weeks during which they were involved with a refuge or another domestic violence agency. Women in the Art Therapy group improved in their self-esteem significantly between baseline and the end-of-treatment. Scores of women in the Person-Centred Therapy group improved greatly after the intervention, that is, between end-of-treatment and follow-up, rather than during the time of therapy. It is therefore possible that Art Therapy might contribute to a quicker improvement in self-esteem.

5.1.1.3. Depression

The majority of women in this sample also suffered from moderate to severe depression as measured by the BDI-II. As with self-esteem, scores on the measure of depression had improved for all women after follow up, i.e. after twenty weeks. The rate at which intervention groups changed however, differed significantly. Shortly after the intervention, at the end-of-treatment data collection, depression had already decreased significantly for women in the Art Therapy group but had slightly increased for women in the Person-Centred group. In the ten weeks after the intervention, depression continued to decrease for Art Therapy participants and also began to decrease for women in the Person-Centred group. Moderate to severe depression was reported by participants in all three experimental conditions at an average 71 percent (rates of depression were very similar across the three groups). The number of women experiencing moderate or severe depression dropped drastically, to 10 percent, after the intervention, for Art Therapy attendees. However, 25 percent of women reported clinical levels of depression at the end of the study in that group. However, due to the large drop out and participant's frustration concerning the completion of questionnaires (for an explanation please see Appendix G) only four women in this experimental condition completed this measure, making an accurate estimate of the long term effect of the intervention on depression in this sample impossible. Several more participants of Person-Centred Therapy actually reported depression after therapy (82%). This number drastically changed however in the ten weeks between the end of therapy and the follow up appointment. At that time, only 25 percent of women still reported moderate to severe depression. Fewer women in the control condition, only 33 percent, reported clinical depression ten weeks after baseline

data was collected. This number increased again however to 50 percent at 20 weeks or the end of the study. Art Therapy seemed to have made a bigger difference for depression, whereas receiving routine services alone might not be sufficient enough in reducing depressive symptoms. The difference between the intervention groups at follow up failed to be statistically significant, a result that might have been due to the considerable attrition rate and a small effect size.

5.1.1.4. General psychological Well-being

At the beginning of the study the majority of women scored within the clinical ranges on all nine subscales of the SCL-90-R, measuring several aspects of general psychological well-being. Women in this sample reported less psychological well-being than women in the general population (according to T-scores for the SCL-90-R). The current data can be compared to samples in other studies of survivors using the same measure. Of particular interest is the large number of women who scored in the clinical ranges on the subscale *Psychoticism*. A closer look at the questions comprising this subscale on the SCL-90-R might illuminate the range of scores. Questions such as “do you feel that there is something wrong with your body/your mind?” are frequently rated high for survivors of domestic violence. One possible explanation could be that women are often told by their abusers that they are unattractive, crazy, or inadequate, etc. As a result, scores on these items might be an indication of low self-confidence and high levels of self-criticalness rather than psychoticism as such. This would call into question the validity of the *Psychoticism* sub-scale of the SCL-90-R for individuals experiencing IPV, an issue that should be investigated in future research.

Although participants in all three conditions improved their psychological wellbeing throughout the time of the study, the improvement happened at different rates for women in the three conditions. The overall measure of global severity (an indication of overall psychological distress) conveyed that women who had attended Art Therapy had also improved their psychological well-being during the intervention and maintained that improvement for 10 weeks after the intervention had ended. Women in the Person-Centred Therapy and control groups only gradually improved their well-being during the 5 months of their involvement in the study. The greatest change between baseline and end-of-treatment was reported by women in the Art Therapy group on the subscales of *Somatisation*, *Interpersonal Sensitivity*, *Depression*, and *Paranoid Ideation*. In comparison to participants of Person-Centred Therapy and women in the control condition, Art Therapy attendees reported a decrease in somatic problems (such as pain, headaches, gastrointestinal concerns, or shortness of breath), feelings of insecurity and worthlessness when dealing with others, sadness, and distrust and suspiciousness *immediately* after their participation therapy. On the other hand, women in the Art Therapy condition reported an increase of concerns related to obsessive-compulsive behaviours and thoughts after the intervention, which decreased again in the ten weeks after the intervention had ended. On the subscale of *Anxiety*, women in the Art Therapy as well as the control condition changed significantly during the intervention in comparison to women who had attended Person-Centred Therapy. For women in the control condition symptoms of anxiety only gradually decreased whereas women who had attended Art Therapy reported an immediate decrease. When it came to feelings of hostility, women who attended Art Therapy as well as women who did not attend either one of the

two therapies (controls) reported gradually improved scores (that is less anger, irritation and aggression) at the end of the study. Phobic anxiety as well as psychoticism changed to a greater extent for women who attended either one of the therapeutic interventions.

5.1.1.5. Symptoms of PTSD

Symptoms of PTSD have been consistently reported to be associated with the experience of IPV (Golding, 1999) and psychotherapy for these symptoms has been recommended by several professionals (Seedat et al., 2005). In the current sample, numerous symptoms were reported at a high level. Art Therapy was particularly effective in reducing several symptoms of PTSD at a faster rate than Person-Centred Therapy or routine intervention alone. Although for all subscales except *Sexual Concerns* and *Dysfunctional Sexual Behaviour*, women generally reported the lessening of symptoms, women receiving Art Therapy reported the greatest change shortly after the intervention in several areas including *Anxious arousal*, i.e. feelings of anxiety, tenseness and nervousness, and *Tension Reduction Behaviour* such as self-mutilation, angry outbursts or suicide threats to reduce internal distress. Art Therapy participants also reported a decrease in depressive symptoms (as measured by the TSI as a symptom of PTSD) at the end-of-treatment measure shortly after the intervention. Symptoms of depression also decreased for participants of the Person-Centred group but only once the intervention had ended, that is, between end-of-treatment and follow-up. There was no change on this measure for women in the control group.

Noteworthy are the significant effects of both therapeutic interventions on *Defensive Avoidance* – frequent attempts to avoid painful thoughts, stimuli or

events in the environment (in other words using avoidance as an active and conscious process to manage distress from traumatic experience), *Impaired Self-reference* indicating an inadequate sense of self and self-knowledge, as well as feelings of anger and irritability. Significant differences between groups were detected on the subscale of *Anger/Irritability* as well as *Defensive Avoidance*. In both cases, at end-of-treatment, women in the control group still reported the highest anger and avoidance behaviour. Art Therapy participants reported the least frequency of defensive avoidance behaviours while women who took part in Person-Centred Therapy reported the least frequency of anger and irritability after therapy. Women in the two therapeutic intervention groups also improved greatly on the subscale of *Impaired Self-reference* (a measure of difficulties associated with an inadequate sense of self and personal identity such as a lack of self-knowledge and self-confidence and a tendency to be easily influenced) as indicated by the results of the Friedman's test. This finding is not surprising as the encouragement of insight and self-discovery is the crux of therapy and has been mentioned frequently by participants in interviews.

In summary, all interventions had an impact on women's general psychological wellbeing. Participation in either of both therapeutic interventions in addition to routine care, however, contributed to improvements in difficulties related to phobic anxiety, psychoticism and impaired self-reference. Art Therapy was particularly effective in improving general psychological wellbeing (i.e. the global severity of symptoms) and in particular self-efficacy, self-esteem, depression, somatic problems and several debilitating symptoms of PTSD, including anxious arousal and avoidance of significant stimuli, shortly after the intervention compared to the control or Person-Centred condition. Most

improvements were reported by participants of Person-Centred Therapy in the areas of self-esteem, depression and anxiety between end-of-treatment and follow-up appointments.

In recent literature, depression was associated with temporal proximity to the abusive relationship (Golding, 1999). In the current study it can also be observed that depression declined with time for women in all conditions. The finding of other researchers that survivors who experience high rates of PTSD might on the other hand experience lower rates of depression (Mruga et al., 2004) could not be supported. In the current sample, women suffered from both, high rates of PTSD symptoms as well as high rates of depression.

Although significant differences between the three intervention groups at the end of the study existed only on the PTSD symptoms of anger/irritability and defensive avoidance, frequent interaction effects imply that therapeutic intervention (and particularly so Art Therapy) can contribute to a quicker recovery from the negative sequelae of domestic violence. Further questions of interest concern factors (such as coping and self-efficacy, length of abusive relationship, time since leaving) and their possible impact on or ability to predict treatment success. In this study, treatment successes are considered improvements in well-being. Willingness or ability to remain in treatment, and similar factors, have not been considered but should be included in future research with survivors.

5.1.2. Differences between Completers and Drop-outs

Altogether 47 percent of participants (n= 24) completed the study and provided data at all three time points. However 53 percent of participants dropped out of the study at some point during the course of five months - 33 percent

dropped out of the study after only completing the baseline measures, which means that participants had either not begun their participation in treatment after completing the questionnaires for the first time, or women dropped out during the 10 weeks of therapy. In some cases, women could not be contacted for data collection once the intervention had ended even though they had participated in all ten weeks of therapy. Although no statistically significant differences were found in attrition rates between groups, participants in the Art Therapy group tended to drop out at a greater rate ($n=12$) than in the other two conditions (Person-Centred group $n=5$ and control group $n=10$). Participants of the Person-Centred group tended to stay in the study more so than women assigned to the other two groups. Reasons for drop out (where available) are discussed in more detail in Appendix G.

Of further interest are differences in psychological well-being between women who remained in the study for at least 10 weeks and those who dropped out after completing only baseline data. Women who dropped out tended to feel significantly worse in regard to somatisation (suffering many somatic complaints such as pains, feelings of weakness or gastrointestinal problems) as well as paranoid ideation (distrust and suspiciousness towards others) than women who continued to take part in a therapeutic intervention - including routine care within a refuge. Women who dropped out also reported more symptoms of PTSD including depression, dissociation, impaired self-reference and tension reduction behaviour. It is possible that women were too unwell to participate or did not believe the intervention could help them.

5.2.3. Changes in coping techniques

Coping was considered and treated as a personality trait rather than a dependent variable or symptom related to mental ill-health. The data in this study do not support the assumption that survivors of domestic violence display dysfunctional coping mechanisms. It is important to recognise that women's actions are important normal and logical responses to the stressful situations and an often unresponsive environment (Seeley, 2002). The label of learned helplessness for these actions is therefore not appropriate.

As expected, therapeutic interventions had little influence on coping traits. There was no change reported by participants in many of the coping techniques including active coping traits such as logical analysis and problem solving and avoidance strategies such as emotional discharge. Interestingly, in the short term analysis (looking only at the impact of the interventions after 10 weeks) it became clear that shortly after the intervention women reported improvement in scores on the seeking guidance subscale (meaning that they were in fact seeking more guidance or looked at guidance more favourably) than before. This change was not maintained, however, whereby it is important to consider the high drop out rate. Because fewer participants remained in the study to complete all three assessments, the short term analysis included more participants. There was equal improvement for all participants on the subscale of positive reappraisal and women reported a general decrease of avoidance coping techniques such as cognitive avoidance, resignation, and seeking alternative rewards.

5.1.4. Predictors of Therapeutic Success

Pearson correlations were used to explore relationships between self-efficacy, self-esteem and coping strategies at baseline and follow-up. Perceived self-efficacy at baseline was positively related to levels of self-esteem and depression after the intervention, at the end-of-treatment. The less women reported perceived self-efficacy at the outset of the study, the less self-esteem and the more depression they reported after the intervention. Greater perceived self-efficacy has been linked to better outcomes when trying to achieve a behaviour change (Strechner, DeVellis, Becker, & Rosenstock, 1986). It is possible that women who had higher perceived self-efficacy also took part in therapy with a more persistent goal of getting better. There might also be a suggestion of coping techniques as indicators of therapeutic outcome. The better able women were to use active coping mechanisms, such as positive reappraisal, the more self-esteem they reported to have, and vice versa – higher self-esteem might also contribute to the ability to use active coping mechanisms. Similarly, the likelihood to use acceptance and resignation as a coping mechanism was related to lower levels of reported self-esteem. The increased use of active coping techniques such as positive reappraisal and less use of avoidance coping such as acceptance and resignation was also related to lower levels of the PTSD symptom of anxious arousal at follow up. Not surprising was also the finding that higher reported self-esteem at the onset of the study was related to lower global severity of symptoms as well as depression at follow up.

5.1.5. Convergent and divergent findings

The baseline psychological profile of women in this sample is comparable to those of other studies and supports the well-established notion that the experience of intimate partner violence is highly correlated with psychological distress. Self-esteem scores in the current sample were slightly lower than those found in Lewis et al (2006). Lewis et al (2006) reported a mean of 19.5 (SD 5.82) while women in the current study reported a mean of 15.7 (SD 4.71) at baseline. The data provided by the women in this sample further conveyed a high percentage of PTSD symptoms as well as symptoms of depression, akin to problems stated by Golding (1999), supporting the opinion of many professionals advocating treatment of PTSD for survivors as urgently necessary (Houskamp, 1994; D. M. Johnson & Zlotnick, 2009). In view of the outcomes of the current study, Art Therapy in particular has lent itself well as time –limited therapeutic intervention as it allowed participants an opportunity express emotions and cognitions related to their experiences in a safe way. Art Therapy offered a way to lessen the emotional numbing and avoidance through naming the violence in the group and by incorporating creative means to assist in dealing with difficult emotions as these elements should be crucial in therapy (Housekamp, 1994).

It has been well established that individuals in all socio-economic and cultural settings can become the victims of domestic violence. However, women in the current sample came mainly from lower socioeconomic backgrounds. This calls for some consideration. It is possible that women with higher income or education also utilise different financial and therapeutic resources when separating from abusive partners. Refuges, particularly so in and around London, might be a first and important point of contact for poorer women or those without family

members close by. The effectiveness of therapeutic interventions in this study has therefore only been examined on a small and available sample of survivors. A comparison with women not using domestic violence agencies was beyond the scope of this project, but future research should focus on the effectiveness of interventions for all women healing from IPV.

5.2. Review of Qualitative Results

Interviews with participants of intervention groups, in this case Art Therapy, were an additional important element of this research project. Qualitative research allows a judgement of therapy from the point of those who experience it (Goss & Rose, 2002) and the responses from participants in the interviews significantly contributed to a deeper understanding and appreciation of how the process of therapy works and whether it is perceived as effective or not. Responses also added knowledge and further meaning to statistical results and offered insight into important elements that concern the process of therapy for survivors.

It became clear that women had used art, as intended, therapeutically. To participants, Art Therapy represented an alternative and valuable mode of expression, it became a symbolic language for things too rude or too painful to describe in words. The relief felt by many women about having the opportunity to “get things off the chest”, lift a burden or to be able to confront their fears, anger and emotional memories in a safe therapeutic environment was clearly visible and explicitly expressed during the interviews. Creativity and art-making became a form of release, a way to communicate worries and thoughts, which would not

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have been discussed during routine care. In this way, art-making also became a problem management strategy.

For some participants, the prospect of having to be creative, however, contributed to more intense feelings of insecurity and low self-confidence before treatment began. Women in the Art Therapy condition reported the lowest level of self-esteem, which might be explained by the trepidations caused by the thought of potential expectations from the therapist, or possibly, the researcher. After the experience, most women reported that self-esteem and confidence had been gained by being able to produce art work, by accomplishing goals set in a therapy session, and by having faced (and worked through) very personal and emotional issues. To some participants, creating and analysing their own art work became the most beneficial part of the process and was regarded as an “eye opener”. Art work was also used as a type of journal or track record of personal processes and achievements during the course of therapy. It has been described by women as helpful to record the process of getting in touch with oneself.

To interviewees, the personal outcome of therapy was manifold. None of them had come to therapy with explicitly stated goals other than to “feel better”.

Women not only reported generally feeling less depressed and better overall as a result of the intervention, but also mentioned having found alternative ways to manage new episodes of depression. Further outcomes included better social skills, feelings of empowerment and increased self-awareness, confidence, and “feeling stronger” (i.e. more assertive, able to make decision on ones own, having a positive attitude or outlook on life). Women were amazed to still become aware of uncovered aspects of their personality and to find new talents. Art Therapy became a way for women to re-identify themselves as well as finding themselves

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anew. *Impaired Self-reference* was a quantitative measure on which many survivors scored within the clinical range. The concept of self was also a major theme in the interviews with art therapy participants. A previously under-examined aspect of therapy might therefore be the re-invention of the self after the experience of abuse. Self-awareness and insight was an important factor that also translated into every day life. Most importantly, seeing themselves as valuable individuals who deserve to be treated in a respectful way was one of the more frequently mentioned cognitive changes resulting from the therapeutic encounter. These feelings of empowerment also outlasted the course of therapy as reported by participants.

Various elements reported by participants to have made this approach a less threatening and beneficial one included the relaxation felt during the sessions, the possibility to release emotions in a safe, creative way and the opportunity to work at one's own pace. Not only the process of art making but also being allowed to work independently, silently and without a pre-set structure was a valued change to other interventions and contributed greatly to feelings of empowerment - each individual's belief in herself, her ability to make decisions, and in her unique path to self-discovery. Women reported several other elements they had found to be therapeutic. These included a safe and supportive environment in which a competent therapist played an important role, having the opportunities for self-awareness and for learning new cognitive and behavioural strategies, and most importantly, having the time for oneself that is spent doing something enjoyable and relaxing.

Participants in the current study highly valued the group approach and the opportunity to connect with other survivors. Being in a group with other survivors

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not only decreased each person's perceived isolation, it also drew out issues about domestic violence that had an emotional impact for all participants. Seeing others with similar problems and experiences helped participants reassess themselves, look at their own lives with abuse and reflect other group members' experience. The sharing of experiences as well as their work was clearly expressed by women as a significant element for therapeutic success. Other functions of the group included the opportunity to not only receive support but also give strength and recount personal experiences for the benefit of others, which seemed an important part in the healing process for many women. It has also been pointed out that the group offered individuals suffering from depression a reason and opportunity to leave the house. In that way, the group was an important anchor to the outside and helped to establish a more functional weekly routine. The end of the therapy sessions meant a significant loss for some participants however. It has been pointed out that this loss also contributed greatly to further distress.

When describing the importance of the group, much weight was placed on the role of the therapist. Her skill and knowledge was one of the most frequently mentioned aspects of therapy. Although information was given beforehand, it seemed that many participants were unclear about the profession of Art Therapy at first. Some participants expected a school-like atmosphere, in which the Art Therapist would act as an art teacher. Therapists were frequently referred to as teachers or "the person sitting in". In that way, women seemed to confuse Art Therapy with art education and were surprised, but pleased, about the unexpected and at times somewhat passive role of the Art Therapist. All therapists who took part in this project were competent professionals who collaborated with the women rather than taking a hierarchical stance. Some therapists achieved that by

participating in drawing or painting alongside the participants. This egalitarianism was appreciated by participants and worked well for the group. Participants also appreciated the independent working style and openness of the therapist towards the group's wishes. All participants interviewed concluded that the Art Therapist played the most central role in their therapy experience.

During interviews a wish for help, such as more support than routine intervention, was frequently disclosed. Personal experiences with violence were also used to further explain the importance of the therapeutic intervention for them. All interviewees agreed that Art Therapy is a worthwhile intervention for survivors of violence and many had suggested that it should be available not only to all survivors but also to all populations in need of therapeutic intervention.

5.3. Knowledge gained through Findings of the Study

The responses given by participants in interviews concur with many quantitative findings. The improvements in well-being revealed by statistical analysis, such as decreased symptoms of depression and increased self-esteem and self-efficacy, have been perceived as such and are reflected in participants' responses. In this way, participants' statements support the findings of the statistical analyses.

However, individual responses also contribute to an explanation of statistical results. Although women in the experimental conditions, and in particular the Art Therapy group, reported a considerable improvement in well-being immediately after therapy, more so than women in the control condition, findings did not significantly differ between the groups at the follow up. This result could have been influenced by a variety of causes including attrition and

personal bias. Participant E. however also describes her feelings at the loss of Art Therapy, which to her contributed largely to “going back to being depressed”. For women who have no further support, particularly those who have moved out of the refuge and into a new area, the therapy group might be the only source of assistance and validation. It is not surprising then, that the loss of this support network caused negative symptoms to reappear.

The combination of qualitative and quantitative findings might also indicate reasons for attrition. As participant K. points out, the time for therapy has to be right, expressing that readiness for change is important for therapeutic success. To many others, having to face personal and painful issues amidst of a new and possibly chaotic living situation might have been too overwhelming at the time. The expectation of having to be creative could have also contributed to the reluctance to engage in therapy as expressed by some participants. Unfortunately, little information is available about the reasons why women chose to withdraw. Informally recorded reasons were most often the move out of the refuge or being evicted from the refuge. Difficulties remaining in treatment however, is an important aspect when considering funding for interventions. It is therefore a valuable focus of future research projects.

Results of the current study also concur with the findings of numerous other researchers examining the differing effects of therapeutic interventions. In a number of studies, no clear differences between therapeutic approaches have been found (Howard, Riger, Campbell, & Wasco, 2003; Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006) but results indicate that all therapeutic interventions are more effective than none. This result has been described as the dodo-bird verdict, the finding that all treatments do equally well and no specific

treatment does better than another (Seligman, 1995). In a research study investigating the outcomes of three contrasting approaches (cognitive behavioural (CBT), Person-centred (PCT) and psychodynamic therapy it was found that, consistently with previous findings, all theoretically different approaches yielded similar outcomes. (Stiles et al., 2006). Neither therapeutic approach chosen in the current project was harmful to participants or fared worse than other approaches examined before. It is therefore not surprising to find out that participants in the current sample appreciated not necessarily specific techniques unique to one approach but rather valued generic therapeutic foundation of most therapeutic encounters. These fundamental elements include having the time and space to work at one's own pace (supporting a client-led approach), the therapeutic atmosphere (feeling secure and supported by peers, and in particular, the therapist) and the validation of feelings without judgement. In previous studies exploring the helpfulness of therapy, similar elements have been identified. Of primary importance in such studies has been the skill and style of the therapist, empathy and a non-judgemental attitude that validated an individual's feelings (Stenius & Veysey, 2005). The idea of Person-Centred Therapy is also based on necessary elements including unconditional positive regard and the authenticity of the therapist (Rogers, 1951), which can be compared to those reported to have been experienced by participants. The therapeutic approach might therefore not be of primary importance as long as a therapeutic foundation can be established. Using expressive means however, can serve the function of establishing that foundation faster than other approaches could. The Art Therapy seemed to have lent itself well to serve several crucial functions in the treatment of survivors. Dutton-Douglas (1992) describes that naming the violence as well as corresponding

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thoughts and emotions is a crucial phase in treatment. This has been achieved to a great extent in the current project through expressive techniques. As expressed by participants, the medium of art also gives women a safe voice for feelings too rude or too painful to describe in words. Art making had become a valuable strategy to manage symptoms of PTSD, such as avoidance and anger, and served as an outlet for negative feelings and cognitions. The guidance of the therapist has thereby been useful in challenging assumptions and cognitions about the abuse that may have been barriers to effective problem solving. In the treatment of trauma, art can facilitate the management of stress (as described by participant N.) as well as the expression of emotion (participant K.). It has been discussed that expressive techniques can be useful in working through anger. For many survivors of IPV the suppression of anger might have been an important adaptation to difficult circumstances, and despite the separation from the abuser, the expression of anger might still cause fear and trepidations (Enns, Campbell, & Courtois, 1997). A second critical point in treatment is the focus on women's impaired identity and self-reference (Houskamp, 1994) and participants frequently mentioned increases self-awareness and having re-identified themselves during the course of Art Therapy. During the intervention participants were also given the opportunity to engage in self-nurturing behaviours in order to establish a sense of individuality, dignity and personal worth (Dutton, 1992).

Although not included in the purpose of this study, therapeutically relevant themes or topics emerged, which may help to further inform choices about treatment in domestic violence agencies. In addition to the mental health effects of abuse, topics of importance for treatment included self-identity, the value of social support and basic plans for the future (such as housing and not being re-

victimised). Survivors do not easily work through their experience on their own but are unambiguous about the wish to discuss their experience of domestic violence as well as a whole scope of feelings relating to those experiences, not just during one meeting with a key worker, but on a regular basis. In many ways, responses from participants also provide backing to the choice of group therapy over individual therapy for survivors. As outlined by other researchers, single sex groups can be beneficial for decreasing isolation, shame and loneliness. Group interventions can also help members (re-)develop a capacity for trust, and help practice interpersonal and coping skills (Enns et al., 1997). In the group, each member should be seen as equal and limiting power dynamics should be avoided. A successful support group is characterised by cohesion and the willingness of group members to help solve problems, regular interpersonal contacts while advocating interdependence in a cooperative and egalitarian atmosphere (Holiman & Schilit, 1991).

5.3.1. Integration of Findings with the Literature

In the past two decades many recommendations for the work with survivors of IPV have been published. And many attempts have been made to incorporate the advice and experience of professionals in the field into the present research project. This concerns the length of therapy, the time and place for intervention offered as well as content and objectives of treatment. Great foci of treatment in the current study were specific therapeutic elements as outlined in section 1.4. These elements include the provision of survivors with opportunities to work through traumatic experiences, to discover and activate personal resources, and to increase self-efficacy and self-esteem as part of empowerment

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within a safe and secure therapeutic atmosphere. Both experimental therapy conditions, Art Therapy and Person-Centred Therapy, were chosen to ensure that these crucial elements of therapy can be offered to survivors.

Because the experience of violence impacts not only the physical but mainly the psychological health of women, the recovery process for survivors of IPV should attend to cognitive as well as emotional responses to the abuse (Holiman & Schilit, 1991). Art Therapy in particular had been chosen successfully to ease the acknowledgement and expression of feelings as well as the change of dysfunctional cognitions, for example that all men are abusive, or that one deserves to be violated. As suggested by Houskamp (1994), by combining therapy with the crucial services provided within refuges, treatment included means to address the dynamics of the violent relationship as well as means to work through the negative effects of trauma. Therefore it is useful to offer treatment in addition to the services provided by the refuge where women focus on the social and educational aspect of domestic violence.

An attempt was also made in the current study to ensure the opportunity for comparisons to other research in the field. The research design and the choice of standardised questionnaires have been led by other examples to make an association achievable. In comparison with similar studies it can be said that the current study supports many of the recent findings of other researchers.

Participants in all conditions improved on important outcome measures, similarly to results reported by Howard et al. (2003) and Stiles (2006) but therapy is particularly helpful in the treatment of depression and PTSD. This outcome is encouraging as the treatment of depression and symptoms of PTSD is suggested to be a crucial part in treatment in therapy with survivors (Seeley, 2002). Results

of the current study can not be fully compared to those of Kubany et al (2004). Although women in the Art Therapy condition report positive changes earlier than women in the other two conditions, considering exclusively statistical results, ten weeks after the end of treatment it can not be said that Art Therapy is superior to Person-Centred Therapy or routine intervention alone.

The positive effect of therapy on the self-esteem and self-awareness, of survivors has been mentioned in a variety of articles outlining the basics of survivors treatment (Seedat et al., 2005). The change in self-esteem is rarely statistically significant when measured with standardised test (Holiman and Schilit, 1991). However, when questioned in interviews, participants reported positive experiences with an intervention, increased self-esteem and further immense benefits as a result of the therapeutic encounter (Holiman & Schilit, 1991). Results of the current study also resemble the outcomes reported by Brooke (1995) in one of the few quantitative studies of Art Therapy for survivors of abuse. Similarly to the women in her study, Art Therapy participants reported an increase in self-esteem shortly after the intervention had come to a close, despite the lack of a statistically significant difference between the groups.

5.4. Implications

Research examining the effectiveness and efficacy of therapeutic interventions are urgently needed in order to provide efficient treatment in practice. The current study is an attempt to help fill the existing gap between research and practice. It is hoped that the findings may influence some of the decision making and funding of effective interventions for survivors in the future. It is also important to point out again that no particular theoretical orientation was

used in order to make an implementation of similar projects in a variety of settings possible. The neutral stance adopted in the course of this research project is hoped to enable researchers and professionals alike to use therapeutic intervention, and in particular Art Therapy, in practice and research.

5.4.1. Contribution of findings to the literature

The findings of the current study contribute to the literature in a number of ways. Firstly, data collected yield results to support important other studies outlining the negative effect of abuse on women, in particular depression and PTSD. This is an important finding as it supports the importance of and justifies the need for effective treatment for women who have experienced IPV. Routine intervention provided by refuges or other domestic violence agencies are crucial, but additional therapeutic treatment can greatly inflate the positive impact these interventions have. The findings of the current study also support previous indications in both the field of Art Therapy as well as domestic violence that treatment for survivors is in fact beneficial. In line with recommendations from Lagorio (1989) and Palmquist (2003), Art Therapy does have a place in practice and adds to the therapeutic repertoire in the work with survivors of domestic violence. Therapeutic treatment can diminish the negative psychological sequelae of violence, which women would not easily face on their own, in less time. Since fast amelioration also contributes to the avoidance of further problems, such as re-victimisation, chronic health problems or long term disability, immediate and effective intervention is crucial.

From a different perspective, the findings of this study add to the knowledge of how participants view Art Therapy and its process on one hand, and their role in treatment and recovery from IPV on the other. Therapeutic

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interventions, such as Person-Centred Therapy and in particular Art Therapy, have the potential to accomplish the important goal of empowerment, even if only used as a brief therapy approach with limited time. It has been asserted that even a single session of Art Therapy can make a difference for an individual (Filip, 1994). Similarly, the study might illuminate the themes that emerge naturally in a therapeutic encounter with survivors when a client-directed stance is taken. Similar themes such as the experience of abuse, dealing with anger and sadness, grieving for losses, and working out one's future, came up across all groups, regardless of the therapeutic approach used (please see the Appendix D for a list of themes). Although a standardised manual for all therapists to use could have simplified the research process, it would have made the replication of the intervention in every day practice more difficult.

Because the problem of IPV highlights issues of power and control, some professionals believe that crucial themes in treatment should be the psychological distress (Monnier, Briggs, Davis, & Ezzell, 2001) as well as empowerment and autonomy (Dutton-Douglas, 1992), particularly in the phases of recovery. Art Therapy has lent itself well to working with women on empowerment as well as issues of autonomy. Further points outlined as important in treatment by Dutton-Douglas (1992) include challenging and changing of dysfunctional cognitions and behaviours, gaining awareness of oneself and one's feelings, and starting to rebuild one's life. As reported by participants in the interviews, the effect of the intervention on the individual's self-awareness and perceived self-efficacy was also a crucial point. Art Therapy participants had been able to face these aspects during their involvement in the project. The important process of empowerment means to enable a person, rather than taking a position of power and responsibility

for that person (Seeley & Plunkett, 2002). That is encouraged through assisting women to identify strengths, coping skills and resources, promoting a sense of entitlement to own opinions and perspectives, acknowledging women as the experts in their lives, and recognising the complexity in each woman's situation (Sharma, 2001). An important point hereby is finding the power within, in other words, the feelings and assertions of strength that originate within an individual in order to the move from victim to survivor and (re-)gain control over ones life. A previously successful programme for survivors in refuges outlined by Johnson and Zlotnick (2009) for example, incorporates not only safety concerns and symptoms of PTSD, it also focuses to a great extent on empowerment. In the current study, empowerment as well as individual well-being (including the decrease of PTSD symptoms) were crucial themes and have been a focal point in therapy.

Another important objective of the current study was to produce research results that are applicable for the use in practice. Many problems were encountered during the course of this project, which are inevitably part of every day interventions. (For a further discussion on difficulties experienced please see Appendix G). Regardless of these obstructions, both experimental interventions played an important part for those who attended as expressed by interviewees and despite numerous drawbacks, both interventions were successfully implemented and a positive result could be achieved.

5.4.2. Implication of findings

Healing from the negative effects of IPV is not an easy process and women encounter many difficulties in their recovery. These difficulties are partly due to the complex nature of the problem as well as the damaging negative

psychological consequences of their experiences. However, women will often participate in their own healing process actively by connecting with others, for example by participating in a therapy group as in this case, or use spirituality as well as restorative activities to nurture themselves (Stenius & Veysey, 2005). Women also choose the appropriate measures and activities according to where they are in their process of recovery. When considering the stages of change model, all participants of the current study were in the 'maintenance' stage, a time when the abusive partner has been left but numerous adversities are faced while many women struggle to maintain a non-victim status and not return to their partners. It can be said that during the 'action' and 'maintenance' stages, survivors are ready for change and most likely to embrace therapeutic intervention. This is an important consideration when trying to generalise the results of this study. As Johnson and Zlotnick (2009) point out, therapeutic experiences can be different for women in the community or women living in refuges. In the community, women may live in a familiar environment but might not have access to the multiple services provided by refuge staff. While in a refuge, women are actively seeking help, and offering treatment during their stay might open various doors that will prevent re-victimisation later on. Although residency in a refuge is said to be a prime time to offer effective intervention (Johnson & Zlotnick, 2009) it remains unclear whether women were particularly open to therapy at that point, or whether it was still too early for a large number of residents, justifying the high amount of drop out. In the current study, because the intervention was designed for and offered to women in the later stages in survivors' recovery, no information is available to illustrate how the intervention would have worked if women had been in earlier stages in the healing process. It is assumed however that an

intervention of that kind would have been neither effective nor possible for women who still lived in the abusive situation or had not yet considered to permanently separate from their partners.

5.5. Limitations

This study has several limitations and caution should be exercised in generalising the findings to other populations. Many difficulties were encountered during the course of the project, which contributed to some extent to the limitations discussed in the following section. Limitations concern the sample size, recruitment methods, standardised treatment, measurement and sampling bias.

5.5.1. Sample Size

The greatest limitation in the current study is its sample size. The intention of the researcher had been to recruit a minimum of 90 participants. Although the project was always exploratory in nature, only 51 women could be recruited to participate in this study. A great number of survivors agreed to take part during preliminary meetings, however only a few women were left when data collection and/or therapy actually began. Often, up to 10 women expressed interest in therapy but once implemented, the therapy group began with an average of only about 4 members. Most refuges are small facilities and access to participants is always limited and further impacted by frequent changes in residents. The small sample size and resulting lack of statistical power could have contributed greatly to the failure to find significant main effects for groups in many main analyses. In addition to the relatively small number of recruited participants, sample size was impacted by significant drop-out. In the current study, the attrition rate was 53

percent. This is equivalent to other studies of a similar nature and many researchers working with survivors of IPV report high rates of attrition (Holiman & Schilit, 1991; McNamara, Ertl, Marsh, & Walker, 1997; Sullivan, Tan, Basta, Rumptz, & Davidson II, 1992; Tutty, Bidgood, & Rothery, 1993). McNamara et al (1997) discuss that retaining participants as well as difficulties with questionnaire completion were major limitations in their study of the effectiveness of refuge interventions. Although a drop out rate of approximately 50% does not seem unusual in the work with this population, it does impact the choice and outcome of quantitative analyses. The causes for attrition are manifold. Participants in this sample scored high on the trauma symptom of defensive avoidance. Some researchers have contributed a high score on that measure to a possible interference with engagement in treatment (Mruga et al., 2004). These elevated rates of this measure could have contributed to the high drop out rate. Kubany et al (2004) report that eighty percent in their study completed the program, those who dropped out were more likely to be younger, less educated, more depressed, and had lower self-esteem at the initial assessment. This finding somewhat resembles that of the current study. As mentioned previously, women living in refuges face an unstable situation accompanied by many significant changes. Participation in therapy (or research) is not likely a priority for many survivors. Because attrition is a problematic aspect of intervention research, several reasons for missing therapy appointments had been identified in a study by Snape et al (2003), relevant causes include a) waiting time as well as the timing of appointments in the day, b) urgency, appointments were more readily taken up if individuals were in a crisis situation, c) the information given beforehand, d) self-image of the patient, i.e. an individual's sense of responsibility for her own health

and well-being and e) personal views on counselling. These aspects or a combination of them could be crucial factors in women's choice to remain in or withdraw from treatment. Additional reasons for drop out could include participants' (and staff members') opinion of the therapist, support from refuge for the intervention, lack of group cohesiveness, coincidence as well as readiness for change of participants.

Attrition is not only a problem for research; it also impacts the therapeutic work with survivors. The (cost-) effectiveness of therapeutic services depends largely on their appropriate use. Missed and cancelled appointments also mean a loss or waste of valuable resources. According to recent studies, up to 20 percent of clients from a variety of client groups who agreed to counselling fail to engage (Snape, Perren, Jones, & Rowland, 2003). In the work with survivors, this number might be even higher. Future research could also illuminate reasons (and possible solutions) for premature ending of therapy further.

5.5.2. Recruitment

All participants were recruited through refuges or domestic violence agencies which collaborated with refuges. Women who took part were therefore either residents of a refuge or had only recently moved at the time baseline measures were collected. The instability of the living situation, being in an unfamiliar environment and the recent loss of many personal belongings might have contributed greatly to increased psychological distress and anxiety. No information has been gathered from survivors living on their own or with friends and families. The psychological profile of participants in this sample might therefore not be comparable to those of survivors within the community.

As mentioned previously, participants were at the action and maintenance stage on their road to recovery. As pointed out in section 1.4.1., the stage of change during which an individual enters treatment greatly impacts the choice of the intervention as well as treatment success. The maintenance stage has been chosen with the knowledge that women at this stage would be ready to embrace the opportunity of therapy and could benefit from it. This could not likely have been achieved if women still lived in constant fear and in close proximity of the perpetrator. It is therefore not clear what Art Therapy (if any) could play for women at earlier stages of change.

5.5.3. Allocation to Groups

A further limitation includes the allocation of participants to intervention groups. Women were not randomly assigned to experimental and control conditions but were offered one choice of treatment depending on the geographic location of the facility. All women in this convenience sample therefore chose their treatment. Participants thereby acknowledged that there are problems worth treating and they believed that the intervention would help them. The belief in the usefulness and value of therapy could therefore have resulted in sampling bias. The addition of a no-treatment control group was hoped to counteract this problem. However, no-treatment in this case meant no additional therapeutic interaction but continuing care through social workers in refuges, which in itself is valuable assistance. There was no comparison control group receiving no treatment at all. An untreated group of survivors living in the community would not only have been difficult to recruit but also unethical to include. Because of the nature of domestic violence and the resulting danger in which some women may live, offering no assistance to those in need of intervention is not in accordance

with neither the counselling profession nor the ethical conduct of the researcher. As a result it is difficult to declare whether improvements in symptoms of depression or PTSD are the result of the intervention or merely the result of time. Since all three groups were beneficial in improving symptoms it is difficult to say what the situation for survivors of IPV would be without any intervention at all. Qualitative information was gathered to bridge this gap and participants in the interviews attributed their improvements to the treatment rather than the passage of time.

Nevertheless, self-selection also limits the generalisability of qualitative results. Participants who also agreed to talk to the researcher in face to face interviews valued the Art Therapy approach and enjoyed being part of the study. None of the participants who had dropped out of treatment or might have had a differing opinion about the intervention could be recruited for an interview. Information resulting from interviews is therefore also biased to a great extent and reflects only the perspectives of those who enjoyed and benefitted from the therapy.

5.5.4. Standardisation and Measurement of Treatment

Because of the client-led focus and nature of the current study, a standardisation of the therapy groups was not feasible. Group themes developed mainly dependent on the participants' current needs, which could not have been foreseen by the researcher or therapists. Because the groups purposely functioned in a very participant-directed manner, no pre-set structure for the sessions was established. The focus of the groups was therefore on individual issues which, albeit similar across all intervention groups, did not include psycho-education on domestic violence as a social issue.

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Themes or topics of sessions were only recorded briefly and informally by therapists but no manual or outline of the groups was composed beforehand.

Themes are listed where available in Appendix D. Unlike in research with treatment using specified techniques, such as CBT, the lack of set topics across all groups as well as specific techniques used will make the replication of this study difficult. However, this approach has been chosen for several reasons. First and foremost, an important goal in therapy with survivors is empowerment. Giving the control over the therapeutic process and experience to those who are supposed to benefit was felt to be a necessary part of therapy. Secondly, to standardise psychological interventions that also reflect every day practice is difficult (Goss & Rose, 2002) and practitioners rarely work from a single pure theoretical stance in the field. All therapists who volunteered for this study worked in a somewhat eclectic way. All confirmed to use mainly a Person-Centred perspective in their work. However, all Art Therapists were trained in the UK, therefore having studied Art Therapy with a psychodynamic background. Although the usefulness of a group outline in terms of research was discussed in detail beforehand with all therapists, none of them wanted to feel pinned down by a manual. Only one group of Person-Centred Therapy was already established and used a previous outline for their group. For all other therapists, though experienced, the research project presented a new experience. It was agreed that standardised treatment was counter to the idea of a client-directed intervention.

Similarly, there are inherent problems with the use of self-report questionnaires. Such measures ask participants to report their emotional states retrospectively (how she had felt during the last week) and leave only a few options. It is likely that women have felt a whole range of emotions but only

record one taking precedence at the time the questionnaire is being completed. Information given by participants about their emotional state and its improvement is subjective and might depend on the time and day the information was given. Self-report questionnaires are therefore often deemed inaccurate (Seligman, 1995). Though this fundamental flaw of questionnaires is an important one to consider, inaccuracies of self-report measures tend to be random rather than systematic. An additional observer could have counteracted this problem somewhat. During the course of the study, feedback on participants' well-being or their improvements had been given on numerous occasions by refuge staff and therapists. However, this happened randomly and informally. In future research, such information should have more weight and could be included in data collection. Multiple observers, such as refuge staff or even friends or family, would improve the accuracy of self-report measures and research method considerably. An additional problem with standardised tests is their inability to assess goals, which have been set by participants for themselves. Particularly survivors of IPV have multiple problems, which might not all be measured by the questionnaires used. Participants might also place priority on problems that go unnoticed by researcher and will adjust their goals accordingly. What it means to be well might often be defined individually by each participant individual (Ryff and Singer, 1996). If such personal goals have been met without the knowledge of the researcher, yet no change has been indicated by standardised measures, one might be more likely to falsely discharge the intervention as ineffective. In order to get an indication of such individual goals several questions have been included in the interviews (see Appendix E for an outline of the interview agenda). In this case, women did not seem to define goals explicitly but came to therapy out of

curiosity as well as wanting to generally feel better and more confident. To women who took part in the interviews, these goals had been accomplished. Although these aspects have been taken into consideration, it is as crucial as ever that researchers find appropriate measurement tools and effective methodology to further collect information and demonstrate conclusive evidence for the usefulness and benefits of Art Therapy (Burleigh & Beutler, 1997).

5.5.5. Bias

Sampling as well as experimenter bias could have impacted the outcome of both quantitative as well as qualitative measures. Firstly, the study might be biased by those who return all questionnaires and those who participate in the first place. Those who responded to the flyers of the researcher and also completed questionnaires might differ quite systematically from those who dropped out or decided not take part. Although measures were taken to simplify the collaboration with the researcher (no postage had to be paid, questionnaires were brought and picked up in person when possible or sent by mail including return envelopes) a large amount of questionnaires at follow up was not returned. It had been assumed by other researchers that those who do less well in treatment, tend to drop out earlier (Seligman, 1995). It can also be assumed that those who were not successful in treatment, possibly due to being able to function less well, or those who did not believe in its effectiveness withdrew before completing the questionnaire. In support of this notion, statistical analyses showed that women who dropped out of treatment in the first 10 weeks, scored higher than others on several measures. No information is available for the effects of an intervention on those women who had dropped out. Similarly, researcher bias might have also played a role. With a background in counselling and therapy, the researcher

believed in the impact and potential value of the appropriate therapeutic intervention. Care has been taken to remain neutral in the process of recruitment and at times of data collection. Supervision with mentors and peers in order to achieve this goal was an important part of the research process.

Both therapeutic interventions were beneficial for survivors and the opportunity for therapeutic intervention even during a stay in a refuge is therefore clearly warranted. Although the gold standard of efficacy research, the randomised controlled trial, could not be achieved here, several reasons can be given for the preference of the current method. Assessment of treatment is usually done with people who actually seek it. In this case, in line with the client-directed nature of the study, random assignment to a treatment group would also have further undermined a woman's own decision and might have impact the strive for empowerment – one very crucial goal of treatment with survivors in the first place. The move toward the ideal of empirically validated treatments seems at odds with the growing number of approaches used in the field of therapy and has been criticised on theoretical as well as methodological grounds (Ponterotto, 2005; Walsh, 2004). Empirically validated treatment include approaches that have been measured and standardised but exclude interventions that work creatively with the situation at hand, and can still be considered 'good and effective therapy'. Better than using only empirically validated treatment approaches and ignoring other good therapies, it is important to consider good quality data from routine practice, or 'practice-based evidence' (Margison et al., 2000). Hence different approaches including qualitative information have been chosen as methods for data gathering. In the current study, serious attempts have been made

to measure the effectiveness of such interventions including their creativity and flexibility to the best of (the researcher's) abilities. Hence quantitative and qualitative methods were used. The gap between research and practice has received a lot of attention and consideration, and the goal has always been to research for practitioners rather than for other researchers. Research in practice operates in the realm of social and moral action, and cannot be compared to research in a sterile and laboratory-like fashion. Practitioners have a different basic orientation to researchers. In practice, the critical attitudes of the scientist, are traded for tolerant attitudes to meet the needs of clients (Oetting, 1982). In practice, skill and therapeutic success do not directly follow scientific knowledge, which is one of the reasons psychotherapeutic treatments are so difficult to empirically investigate.

5.6. Recommendations

Suggestions for further implementation of the current findings are based on the fruitful combination of services provided by refuges and the therapeutic opportunities offered to survivors through Person-centred Therapy and Art Therapy.

5.6.1. Recommendations for Practice

Based on the experience gained in this study, some suggestions for the work with survivors in refuges can be made. These are in agreement with and an extension of similar points made by other professionals (Enns et al., 1997; D. M. Johnson & Zlotnick, 2009; Seeley & Plunkett, 2002) and should be considered when providing therapy within refuges. Firstly, because time in refuges cannot be

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compared to the established routine women might have had in their own home; therapists should be flexible in regard to scheduling of sessions as well as cancellations. Often, speaking with participants about an appointment time beforehand will lessen the frustration about cancelled appointments or ‘no shows’ later on. Secondly, child-care must be available while the session takes place in order to enable participants with children to take undivided time for her. Thirdly, refuge staff should be informed about the therapy and what it might entail. Any concerns on both sides should be discussed so that cooperation and coordination are possible. In the current study, rooms were often shared between a therapist and staff and lack of communication between the two parties lead to frustration on both sides and for participants. Refuge staff should also be able to answer potential questions about the therapy. Further, in order to facilitate a positive therapeutic alliance, the therapist should not have any other roles in the refuge (such as management, finances, etc.). Also, rooms should be made available for therapy to enable women to create a safe therapeutic space in which they should not be interrupted. In the case of Art Therapy, safe space should also be made available to store women’s art work between the sessions. These pieces of work are very personal and a disregard for them can feel like further abuse and a violation to the creator. Additional important recommendations include the skill and knowledge of the therapist, the nature of the groups as well as the time limit of the therapeutic encounter. In order to offer appropriate treatment, regardless of the theoretical orientation used, any mental health professional in the work with survivors should be sensitive to the special issues survivors of IPV present. The therapist should, for example, be knowledgeable about the nature, dynamics as well as effects of IPV and be particularly aware of possible ongoing safety issues

even within a refuge (Enns et al., 1997; Seeley & Plunkett, 2002). Therapists should also avoid a hierarchical or authoritarian stance with survivors in their struggle to regain respect and power. A work based on collaboration and egalitarianism within the therapeutic context should therefore be preferred. Art can work here particularly well as a common denominator for both the women as experts on their lives and work, and the therapist. An appreciation of such a therapeutic collaboration was also reflected in interviews. Art as media in therapy can also bridge cultural gaps. As in any intervention however, cultural perspectives play an important part in the recovery from domestic violence as well and should always be considered to ensure effective treatment. When dealing with diverse clients, creativity, consideration and flexibility are called for.

Further, as discussed by Monnier et al. (2001), due to the sensitive nature of the participants' problems, groups should not be open to new participants if at all possible. Therapeutic atmosphere, including group cohesiveness as well as the support and positive regard from other members, was an important issue for participants in the current study and was reported to contribute to the group's success. Change, as well as the maintenance of positive changes, depends very much on a continuing support system and appropriate therapeutic measures or referrals (Burman, 2003; Frasier, Slatt, Kowlowitz, & Glowa, 2001). The results of this study show that therapeutic intervention can take the place of a consistent support system during that change process. Therapists leading a therapeutic group should ensure that group members avoid criticism of others' lives and decisions and women must have the opportunity to talk about their experiences in an empathic and non-critical environment (Levendosky et al., 2004). And lastly, many previously explored treatments were offered to survivors for 10 weeks, lasting 1.5

hours (Monnier et al., 2001). Although the limited time of therapy was criticised by many Art Therapy participants, it presents an opportunity that is less overwhelming for women. Often, long-term intervention is not possible during the brief stay of women at refuges. Women might say that need or desire counselling while in a refuge but for many it is early, resulting in a higher withdraw rate. However, statistical analyses show that an interaction effect of time and the Art Therapy group was frequently significant - well-being changed during the therapeutic intervention, was then either maintained or decreased again. This development might indicate that the intervention was indeed too brief, as participants assert. As outlined by one participant, the loss of the therapy group also caused symptoms to reappear. An opportunity for ongoing treatment is therefore of great importance. Further research is needed to illuminate how many sessions are appropriate, feasible and would add to more significant results. In practice it might therefore be useful to offer a continuing programme in a similar form after the ten week intervention group, so that positive changes can be continued. The opportunity for further involvement could be given in the form of ongoing individual therapy, a possibility to join an ongoing or new group in the refuge, as well as contact information for additional therapeutic opportunities (if available) for women who leave the refuge.

5.6.1 Recommendations for Research

According to Paul (1967) studies must examine not just the effectiveness of given treatments, but what treatment, by whom, is most effective for this individual with that specific problem under which set of circumstances. It is not clear from the results of the current study whether some patients benefit from Art

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Therapy more than others. It is possible that personal factors (such as creativity or willingness to engage in creative means) play a crucial role that could be examined more closely in future research. Since relatively few studies exist that empirically examine the effectiveness and efficacy of therapeutic interventions for survivors of domestic violence, and even fewer studies, which illustrate the effects of Art Therapy on this population, more research is still needed to create a more comprehensive picture of what is most beneficial as well as cost-effective in the work with survivors. Research is also needed to understand whether the Art Therapy approach, or the Person-Centred Therapy perspective, works better or possibly less well for different individuals. It is important to note at this point that adverse effects of therapy were not assessed. Although harm resulting from treatment was not anticipated, a question, particularly as part of qualitative measures, could have indicated whether women also experienced negative effects as a result of the intervention. Also not assessed were possible cultural differences in responding to questionnaires or individual roles in recovery (Riff & Singer, 1996). Considering culture-dependent attitudes are an important function to ensure both – a lack of harm to participants as well as multicultural practice and research

In the current study, women were presented with either form of therapy and could choose whether to participate or not. Some women, who disliked the idea of having to create art for various reasons but who could have benefited from this type of therapy, were therefore already excluded from the study. Responses from participants in the interviews imply that the foundation and background of Art Therapy had not been completely understood in all cases. Despite the explanation given to participants in preliminary meetings to inform them about

the type of therapy, a more detailed description of the process and the objectives of Art Therapy could have counteracted possible reluctance to engage in the study. Future research should take the importance of detailed information into account.

Avoidance of re-victimisation in the future and goal oriented behaviour or future plans of participants have not been assessed in the current study but are an important additional indication of therapy effectiveness. However, future plans were not assessed with quantitative measures and was only available from interviewees. Follow up information did therefore not include the potential intention to return to abusive partners. Participants who could be contacted for information at follow-up were still separated but nothing is known about those who withdrew from the study or did not respond.

Researchers wanting to improve and replicate a study of this nature should advocate a close working relationship between therapists and refuge staff. This is important as the therapeutic intervention should not be improvised if possible and care should be taken to establish and integrate the intervention into the routine of the agency. Appropriate rooms should therefore be offered, which also include the appropriate equipment. A further suggestion for research in the future concerns the length of the intervention. Several groups should be offered in one refuge back to back so that the intervention becomes an integrated and well-established part of the work within the agency. A long-term involvement of a therapist in a refuge, even just for research purposes, can simplify this process, which in turn results in a higher number of participants. Some measures should be taken in order to avoid attrition in the work with this population. In studies reporting similar problems it has been found out that participants who received at least 6 sessions were more

likely to remain longer than those who did not (Hien, 2004). When implementing an intervention (in research or practice) appropriate measures should be taken in future research in order to reduce the drop-out rate. Researchers need to address the causes of drop-out and examine more closely what specific interventions can meet the needs of short-term shelter users. Money or gift certificates for participants who provide follow-up information could be an incentive to remain in treatment and enable researchers to achieve more valid and useful results.

5.6.3. Concluding Comments

The findings of qualitative and quantitative analyses indicate that therapy, and in particular Art Therapy, is useful and beneficial for survivors of domestic violence. Interviews in addition suggest that therapy is wanted and appreciated by the majority of refuge residents as some feel that routine intervention is not always sufficient. Group therapy can be a useful and beneficial addition and is feasible for survivors in refuges albeit not all residents might be able to take part in therapy at the time of their stay.

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APPENDIX A LETTERS TO PARTICIPANTS AND REFUGES

Information for Research Participants

Dear Participant,

My name is Steffi Winter-Martin and I am a research student at Roehampton University in London. I have had a long interest in helping survivors of domestic violence and in the past have worked with both children and adults who have experienced abuse at home. In my research I am investigating ways to help women work through their experiences.

If you would like to participate in my study it is important that you read the following information carefully, so that you are completely aware what your consent to participate in my study will involve.

If you are unclear about something or if you have additional questions please feel free to contact me or my mentor so that we can answer your questions and resolve your concerns.

The purpose of this study:

Therapy is known to be very effective for many people who feel overwhelmed with a situation in their lives or are unable to get out of a condition without the help of others. For example, group therapy is a valuable method for treating depression, increasing self-esteem or finding support when dealing with an illness.

My research goal is to examine how effective group therapy is specifically for survivors of domestic violence. I would like to understand if and how women feel differently after therapy and whether they are able to gain a new sense of themselves, their situation and possibly their futures because of their therapeutic experiences.

Your benefits:

Your contribution to this research project may make a difference for many domestic violence survivors in the future. Although you are not getting paid to participate your attendance in the treatment sessions might give me and other researchers a better understanding of how therapy affects you and other women like you. Although this treatment is part of a study it has the same benefits as any other form of therapy. If you decide to participate you will have the opportunity to work on your personal problems within this group setting just like you would in treatment at another place.

Your Risks:

All therapy sessions are lead by experienced professionals in the field who are understanding of your situation and will be aware of the difficulties and challenges you have.

Although the group leaders will know how to react in all situations there will be times when the group discusses topics, such as traumatic experiences with batterers, that might make you uncomfortable.

What you can expect:

Appendix A

You will be asked to fill in several questionnaires at various times and attend weekly group therapy sessions for 10 weeks. Therapy sessions will last 1 ½ hours and you will work discuss different topics every week. Even if you happen to move out of the refuge during those 10 weeks you may continue therapy if you wish. There are five surveys/questionnaires you will have to fill out before you attend group therapy and after you have completed therapy. You will also be asked to fill out questionnaires 10 weeks after you have completed the group therapy. These questionnaires will ask you general questions concerning your well-being. For example, you might be asked to rate statements such as “It is easy for me to stick to my aims and accomplish my goals” or “I take a positive attitude towards myself”.

Confidentiality:

I know that your experiences are very personal and difficult to discuss. I assure you that all information you give me in questionnaires or in an interview will be treated confidentially. Strict confidentiality will also be strongly encouraged in all group therapy sessions. I will keep your personal information stored safely and secretly and it will not be given out unless I am worried about your health and safety or that of someone close to you (see below). You will not have to write your name on any of the questionnaires, only on the consent form, which indicates your agreement to participate in this study.

The consent form will be locked away separately from all other information you give. Each survey or questionnaire has a different code number instead of your name, which only I will know. In the publication of any results of this study you will not be identify in any way.

Limits of Confidentiality:

I have to advice you that if during the time of treatment or our work together something comes up that makes me worry about the possibility of you hurting yourself or someone else, I will have to talk to you and the appropriate persons so we can make sure you get help. This is simply for your protection.

Your right to withdraw from the study:

Even if you have signed the consent form and have agreed to participate in my study, you have the right to withdraw from any part of the study at any time – without any objection. You can also change your mind and withdraw from the study after you have participated in several or all therapy sessions without having to give a reason.

Thank you for your participation. Your help is greatly appreciated.

Information for Therapists and Refuge Workers

Dear Therapist, Dear Refuge Director,

My name is Steffi Winter-Martin and I am a research student at Roehampton University in London. I have been interested in the area of domestic violence for a number of years and have made it my goal to learn more about therapeutic possibilities available to survivors of domestic violence. I have also worked as a counsellor with both children and adults who have experienced abuse at home in the past. In my research I focus on ways to help women work through their experiences.

If you are interested in assisting me in this study, either as a therapist or refuge worker, please read the following information to learn more about what this study entails.

If you are unclear about something or if you have additional questions please feel free to contact me or my supervisor so that we can answer your questions and resolve your concerns.

The purpose of this study:

Many therapists and researchers agree that therapy can be a valuable component in the healing process for individuals who have suffered from trauma and abuse. My research goal is to examine how effective group therapy (in particular person-centred therapy and art therapy) is specifically for survivors of domestic violence. I would like to understand if and how women feel differently after therapy and whether they are able to gain a new sense of themselves, their situation and possibly their futures because of their therapeutic experiences.

Your benefits:

By offering your services and expertise in the course of this study you may make a difference for many domestic violence survivors in the future. As mental health professionals, the well-being of each client is a priority and much time is spent on finding ways to provide quality services. Gaining an understanding of how to assist clients better can help not only the professions of art therapy and counselling but may also promote the developments in the field of domestic violence. Although you are not getting paid to participate, your support and expertise might give me and other researchers a better understanding of how therapy affects survivors of violence and trauma. This study is not intended to interfere with routine procedures of the refuge and will not impact the work of the refuge in any way. All women who are willing to participate will be informed of the purpose of the study as well as its benefits and its risks.

What this study requires:

All participating women will be asked to complete six questionnaires at various times. Participants in your refuge may be asked to attend weekly group therapy sessions for 10 weeks additionally or they may be asked to simply complete the questionnaires at three different times in a period of six months. Participants may also be asked if they would like to participate in an interview or a focus group after the completion of treatment. Therapy sessions

Appendix A

will last 1 ½ hours and will focus on different topics every week. The topics include self-esteem, managing traumatic experiences, self-efficacy, and depression. The questionnaires will ask general questions concerning the participant's well-being. For example, a woman might be asked to rate statements such as "It is easy for me to stick to my aims and accomplish my goals" or "I take a positive attitude towards myself".

Confidentiality:

I am aware that survivors of domestic violence have experienced situations that are very personal and difficult to discuss. Each resident, as well as each staff member and therapist, will be treated with respect and in an appropriate manner. All information gathered through questionnaires or through interviews with any of the clients will be treated confidentially by the researcher. Strict confidentiality will also be strongly encouraged in all group therapy sessions. Personal information will be stored safely and secretly and it will not be given out unless I am worried about a participant's health and safety or that of someone close to her. If this situation should arise I intend to discuss it immediately with the refuge director.

No participant will be asked to write her name on any of the questionnaires, only on the consent form, which indicates her agreement to participate in this study.

The consent form will be locked away separately from all other information. Each survey or questionnaire has a different code number only known to the participant instead of the participant's name.

The location and name of the refuge or those of its residents will not be disclosed to any third party or in the publication of any results of this study. The names of therapists will not be disclosed in any form unless consent is given by the therapist.

Your right to withdraw from the study:

Even if you have signed the consent form and have agreed to assist me in my study, you have the right to withdraw that consent at any time – without any objection.

Thank you very much for your assistance. It is greatly appreciated.

My contact information:

Name: Stefanie Winter-Martin,
Roehampton University, School of Human and Life
Sciences

Contact Address: Roehampton University, Whitelands College
Holybourne Avenue
London, SW15 4JD

Phone No: 02083923000x4561 Email: s.winter@roehampton.ac.uk

Director of Studies: Prof. Claus Voegelé

Appendix A

Phone No: 020 8392 3510 Email: c.vogele@roehampton.ac.uk



Dear Participant,

Amazingly, the 10 weeks of our therapy group are coming to an end soon. I hope being part of this group was a positive and interesting experience for you.

I would like to thank you again for your participation and especially for making this research project possible.

As you know, a very big part of the project is yet to be finished. I would very much like your feedback on the past weeks in person and through the questionnaires and would therefore appreciate if you could meet with me on Wednesday 11.07.2007 at _____ Women's Aid at 10:30 in the morning.

I know that completing the questionnaires is a very tedious, boring and also personal process. I very much understand how you feel and will keep my promise of confidentiality.

However, the questionnaires are an extremely important way for me to see what works for individuals in similar situations and how services can be improved. I therefore depend on feedback from each of you.

Thank you again for all your help and support. I very much look forward to seeing you on the 11th July at 10:30.

Best wishes,

Steffi

My contact information:

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Holybourne Avenue
London, SW15 4JD

Phone No: 02083923000x4561 Email: s.winter@roehampton.ac.uk



Dear Participant,

Thank you very much for your feedback, time, understanding and support during the past weeks. I wanted to let you know that I greatly appreciate your engagement as a participant in this research project.

Your contribution has made an immense difference not only for me but for other women going through similar situations. It is still my goal to help women by securing funding for services that really help. I could not have done that without you.

I hope to summarise and write about the results of the study in the upcoming year. Please feel free to contact me any time if you are interested in the outcomes or any further aspect of the project.

I have really enjoyed working with you and I wish you the best of luck for the future!

Sincerely,

Steffi Winter-Martin

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Name: Stefanie Winter-Martin,
Roehampton University, School of Human and Life
Sciences

Contact Address: Roehampton University, Whitelands College
Holybourne Avenue
London, SW15 4JD

Phone No: 02083923000x4561 Email: s.winter@roehampton.ac.uk

1. Information for Research Participants

Dear Participant,

My name is Steffi Winter-Martin and I am a research student at Roehampton University in London. I have had a long interest in helping survivors of domestic violence and in the past have worked with both children and adults who have experienced abuse at home. In my research I am investigating ways to help women work through their experiences.

If you would like to participate in my study it is important that you read the following information carefully, so that you are completely aware what your consent to participate in my study will involve.

If you are unclear about something or if you have additional questions please feel free to contact me or my mentor so that we can answer your questions and resolve your concerns.

The purpose of this study:

Therapy is known to be very effective for many people who feel overwhelmed with a situation in their lives or are unable to get out of a condition without the help of others. For example, group therapy is a valuable method for treating depression, increasing self-esteem or finding support when dealing with an illness.

My research goal is to examine how effective group therapy is specifically for survivors of domestic violence. I would like to understand if and how women feel differently after therapy and whether they are able to gain a new sense of themselves, their situation and possibly their futures because of their therapeutic experiences.

Your benefits:

Your contribution to this research project may make a difference for many domestic violence survivors in the future. Although you are not getting paid to participate your attendance in the treatment sessions might give me and other researchers a better understanding of how therapy affects you and other women like you. Although this treatment is part of a study it has the same benefits as any other form of therapy. If you decide to participate you will have the opportunity to work on your personal problems within this group setting just like you would in treatment at another place.

Your Risks:

All therapy sessions are lead by experienced professionals in the field who are understanding of your situation and will be aware of the difficulties and challenges you have.

Although the group leaders will know how to react in all situations there will be times when the group discusses topics, such as traumatic experiences with batterers, that might make you uncomfortable.

What you can expect:

You will be asked to fill in several questionnaires at various times and attend weekly group therapy sessions for 10 weeks. Therapy sessions will last 1 ½ hours and you will work discuss different topics every week. Even if you

Appendix A

happen to move out of the refuge during those 10 weeks you may continue therapy if you wish. There are five surveys/questionnaires you will have to fill out before you attend group therapy and after you have completed therapy. You will also be asked to fill out questionnaires 10 weeks after you have completed the group therapy. These questionnaires will ask you general questions concerning your well-being. For example, you might be asked to rate statements such as “It is easy for me to stick to my aims and accomplish my goals” or “I take a positive attitude towards myself”.

Confidentiality:

I know that your experiences are very personal and difficult to discuss. I assure you that all information you give me in questionnaires or in an interview will be treated confidentially. Strict confidentiality will also be strongly encouraged in all group therapy sessions. I will keep your personal information stored safely and secretly and it will not be given out unless I am worried about your health and safety or that of someone close to you (see below). You will not have to write your name on any of the questionnaires, only on the consent form, which indicates your agreement to participate in this study.

The consent form will be locked away separately from all other information you give. Each survey or questionnaire has a different code number instead of your name, which only I will know. In the publication of any results of this study you will not be identified in any way.

Limits of Confidentiality:

I have to advise you that if during the time of treatment or our work together something comes up that makes me worry about the possibility of you hurting yourself or someone else, I will have to talk to you and the appropriate persons so we can make sure you get help. This is simply for your protection.

Your right to withdraw from the study:

Even if you have signed the consent form and have agreed to participate in my study, you have the right to withdraw from any part of the study at any time – without any objection. You can also change your mind and withdraw from the study after you have participated in several or all therapy sessions without having to give a reason.

Thank you for your participation. Your help is greatly appreciated.

2. Research Participant Consent Form (Art Therapy Participants)

Consent Statement:

I have received and read the information sheet about the study in which I agree to participate. I am informed about the purpose of the study and I am aware that I am free to withdraw from the study at any point without any objections.

I understand that all information I provide will be treated in confidence by the researcher and that my identity will not be disclosed in the publication of any findings. It is my understanding that my name or other personal information will not be revealed on any art work or in any presentation thereof.

Name: _____

Signature: _____

Date: _____

I give my consent to the display of my personal art work

- ☐ during the project
- ☐ after the project
- ☐ in any publication of the research findings by the researcher

I do **not** consent to the display of my personal art work

- ☐ I direct that my art work be returned to me.

Name: _____

Signature: _____

Date: _____

Please be aware: if you have any concerns or questions about any aspect of your participation, please do not hesitate to contact the researcher or her supervisor.

Name: Stefanie Winter-Martin,
Roehampton University

Phone: 020 8392 3000 x4561 **Email:** s.winter@roehampton.ac.uk

3. Research Participant Consent Form (Person-Centred Therapy Participants)

Consent Statement:

I have received and read the information sheet about the study in which I agree to participate. I am informed about the purpose of the study and I am aware that I am free to withdraw from the study at any point without any objections.

I understand that all information I provide will be treated in confidence by the researcher and that my identity will not be disclosed in the publication of any findings.

Name: _____

Signature: _____

Date: _____

Please be aware: if you have any concerns or questions about any aspect of your participation, please do not hesitate to contact the researcher or her supervisor.

Name: Stefanie Winter-Martin,
Roehampton University, School of Human and Life Sciences

Contact Address: Roehampton University, Whitelands College
Holybourne Avenue
London, SW15 4JD

Phone No: 02083923000x4561 Email: s.winter@roehampton.ac.uk

Director of Studies: Prof. Claus Voegelé

Phone No: 020 8392 3510 Email: c.vogele@roehampton.ac.uk

4. Research Participant Consent Form (Controls)

Consent Statement:

I have received and read the information sheet about the study in which I agree to participate. I am informed about the purpose of the study and I am aware that I am free to withdraw from the study at any point without any objections.

I understand that all information I provide will be treated in confidence by the researcher and that my identity will not be disclosed in the publication of any findings.

Name: _____

Signature: _____

Date: _____

Please be aware: if you have any concerns or questions about any aspect of your participation, please do not hesitate to contact the researcher or her supervisor.

Name:	Stefanie Winter-Martin, Roehampton University, School of Human and Life Sciences	
Contact Address:	Roehampton University, Whitelands College Holybourne Avenue London, SW15 4JD	
Phone No:	02083923000x4561	Email: s.winter@roehampton.ac.uk
Director of Studies:	Prof. Claus Voegele	
Phone No:	020 8392 3510	Email: c.vogele@roehampton.ac.uk

5. Interview Consent Form

I would very much like to hear about your experience over the past 10 weeks of therapy and I am interested in your opinion. For that reason I would like to invite you to a personal interview with me.

Please let us know if you would like to speak to us further.
We will not contact you regarding the interview unless you give us your permission.

☐ **Yes, I would like to participate in an interview.**

Name: _____

Signature: _____

Date: _____

Please indicate where and when it would be safe for us to contact you in the upcoming weeks:

I can best be reached as follows (Address, Email, or Mobile number):

At this time:

☐ **No thanks, I am not interested in participating in an interview.**

6. New Contact Information

If you should move out of the refuge (or away) during the course of this project, please complete and send the following form to me so I know how to best reach you. Thank you!!

I have moved!

In the upcoming weeks I can be contacted safely under the following address:

And the following phone number:

At this time of the day/week:

It is / is not safe to leave a message. (Please circle)

7. Thank-you letter to participants



Dear Participant,

Thank you very much for your feedback, time, understanding and support during the past weeks. I wanted to let you know that I greatly appreciate your engagement as a participant in this research project.

Your contribution has made an immense difference not only for me but for other women going through similar situations. It is still my goal to help women by securing funding for services that really help. I could not have done that without you.

I hope to summarise and write about the results of the study in the upcoming year. Please feel free to contact me any time if you are interested in the outcomes or any further aspect of the project.

I have really enjoyed working with you and I wish you the best of luck for the future!

Sincerely,

Steffi Winter-Martin

My contact information:

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Information for Therapists and Refuge Workers

Dear Therapist, Dear Refuge Director,

My name is Steffi Winter-Martin and I am a research student at Roehampton University in London. I have been interested in the area of domestic violence for a number of years and have made it my goal to learn more about therapeutic possibilities available to survivors of domestic violence. I have also worked as a counsellor with both children and adults who have experienced abuse at home in the past. In my research I focus on ways to help women work through their experiences.

If you are interested in assisting me in this study, either as a therapist or refuge worker, please read the following information to learn more about what this study entails.

If you are unclear about something or if you have additional questions please feel free to contact me or my supervisor so that we can answer your questions and resolve your concerns.

The purpose of this study:

Many therapists and researchers agree that therapy can be a valuable component in the healing process for individuals who have suffered from trauma and abuse. My research goal is to examine how effective group therapy (in particular person-centred therapy and art therapy) is specifically for survivors of domestic violence. I would like to understand if and how women feel differently after therapy and whether they are able to gain a new sense of themselves, their situation and possibly their futures because of their therapeutic experiences.

Your benefits:

By offering your services and expertise in the course of this study you may make a difference for many domestic violence survivors in the future. As mental health professionals, the well-being of each client is a priority and much time is spent on finding ways to provide quality services. Gaining an understanding of how to assist clients better can help not only the professions of art therapy and counselling but may also promote the developments in the field of domestic violence. Although you are not getting paid to participate, your support and expertise might give me and other researchers a better understanding of how therapy affects survivors of violence and trauma. This study is not intended to interfere with routine procedures of the refuge and will not impact the work of the refuge in any way. All women who are willing to participate will be informed of the purpose of the study as well as its benefits and its risks.

What this study requires:

All participating women will be asked to complete six questionnaires at various times. Participants in your refuge may be asked to attend weekly group therapy sessions for 10 weeks additionally or they may be asked to simply complete the questionnaires at three different times in a period of six months. Participants may

also be asked if they would like to participate in an interview or a focus group after the completion of treatment. Therapy sessions will last 1 ½ hours and will focus on different topics every week. The topics include self-esteem, managing traumatic experiences, self-efficacy, and depression. The questionnaires will ask general questions concerning the participant's well-being. For example, a woman might be asked to rate statements such as "It is easy for me to stick to my aims and accomplish my goals" or "I take a positive attitude towards myself".

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The location and name of the refuge or those of its residents will not be disclosed to any third party or in the publication of any results of this study. The names of therapists will not be disclosed in any form unless consent is given by the therapist.

Your right to withdraw from the study:

Even if you have signed the consent form and have agreed to assist me in my study, you have the right to withdraw that consent at any time – without any objection.

Thank you very much for your assistance. It is greatly appreciated.

My contact information:

Name: Stefanie Winter-Martin,
Roehampton University, School of Human and Life Sciences

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Director of Studies: Prof. Claus Voegelé

Phone No: 020 8392 3510 Email: c.vogele@roehampton.ac.uk

Dear Participant,

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I would like to thank you again for your participation and especially for making this research project possible.

As you know, a very big part of the project is yet to be finished. I would very much like your feedback on the past weeks in person and through the questionnaires and would therefore appreciate if you could meet with me on Wednesday 11.07.2007 at _____ Women's Aid at 10:30 in the morning.

I know that completing the questionnaires is a very tedious, boring and also personal process. I very much understand how you feel and will keep my promise of confidentiality.

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Thank you again for all your help and support. I very much look forward to seeing you on the 11th July at 10:30.

Best wishes,

Steffi

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Roehampton University, School of Human and Life
Sciences

Contact Address: Roehampton University, Whitelands College
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Phone No: 02083923000x4561 Email: s.winter@roehampton.ac.uk

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I have really enjoyed working with you and I wish you the best of luck for the future!

Sincerely,

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Beck Depression Inventory

Choose one statement from among the group of four statements in each question that best describes how you have been feeling during the **past few days**. Circle the number beside your choice.

1	0 I do not feel sad. 1 I feel sad. 2 I am sad all the time and I can't snap out of it. 3 I am so sad or unhappy that I can't stand it.	8	0 I don't feel I am any worse than anybody else. 1 I am critical of myself for my weaknesses or mistakes. 2 I blame myself all the time for my faults. 3 I blame myself for everything bad that happens.
2	0 I am not particularly discouraged about the future. 1 I feel discouraged about the future. 2 I feel I have nothing to look forward to. 3 I feel that the future is hopeless and that things cannot improve.	9	0 I don't have any thoughts of killing myself. 1 I have thoughts of killing myself, but I would not carry them out. 2 I would like to kill myself. 3 I would kill myself if I had the chance.
3	0 I do not feel like a failure. 1 I feel I have failed more than the average person. 2 As I look back on my life, all I can see is a lot of failure. 3 I feel I am a complete failure as a person.	10	0 I don't cry any more than usual. 1 I cry more now than I used to. 2 I cry all the time now. 3 I used to be able to cry, but now I can't cry even though I want to.
4	0 I get as much satisfaction out of things as I used to. 1 I don't enjoy things the way I used to. 2 I don't get any real satisfaction out of anything anymore. 3 I am dissatisfied or bored with everything.	11	0 I am no more irritated by things than I ever am. 1 I am slightly more irritated now than usual. 2 I am quite annoyed or irritated a good deal of the time. 3 I feel irritated all the time now.
5	0 I don't feel particularly guilty. 1 I feel guilty a good part of the time. 2 I feel quite guilty most of the time. 3 I feel guilty all of the time.	12	0 I have not lost interest in other people. 1 I am less interested in other people than I used to be. 2 I have lost most of my interest in other people. 3 I have lost all of my interest in other people.
6	0 I don't feel I am being punished. 1 I feel I may be punished. 2 I expect to be punished. 3 I feel I am being punished.	13	0 I make decisions about as well as I ever could. 1 I put off making decisions more than I used to. 2 I have greater difficulty in making decisions than before. 3 I can't make decisions at all anymore.
7	0 I don't feel disappointed in myself. 1 I am disappointed in myself. 2 I am disgusted with myself. 3 I hate myself.	14	0 I don't feel that I look any worse than I used to. 1 I am worried that I am looking old or unattractive. 2 I feel that there are permanent changes in my appearance that make me look unattractive. 3 I believe that I look ugly.

15	0 I can work about as well as before. 1 It takes an extra effort to get started at doing something. 2 I have to push myself very hard to do anything. 3 I can't do any work at all.	19	0 I haven't lost much weight, if any, lately. 1 I have lost more than five pounds. 2 I have lost more than ten pounds. 3 I have lost more than fifteen pounds. (Score 0 if you have been purposely trying to lose weight.)
16	0 I can sleep as well as usual. 1 I don't sleep as well as I used to. 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. 3 I wake up several hours earlier than I used to and cannot get back to sleep.	20	0 I am no more worried about my health than usual. 1 I am worried about physical problems such as aches and pains, or upset stomach, or constipation. 2 I am very worried about physical problems, and it's hard to think of much else. 3 I am so worried about my physical problems that I cannot think about anything else.
17	0 I don't get more tired than usual. 1 I get tired more easily than I used to. 2 I get tired from doing almost anything. 3 I am too tired to do anything.	21	0 I have not noticed any recent change in my interest in sex. 1 I am less interested in sex than I used to be. 2 I am much less interested in sex now. 3 I have lost interest in sex completely.
18	0 My appetite is no worse than usual. 1 My appetite is not as good as it used to be. 2 My appetite is much worse now. 3 I have no appetite at all anymore.		

SCORING

1 – 10: These ups and downs are considered normal.
11 – 16: Mild mood disturbance
17 – 20: Borderline clinical depression
21 – 30: Moderate depression
31 – 40: Severe depression
over 40: Extreme depression

Rosenberg Self-Esteem Scale (Rosenberg, 1965)

Below is a list of statements dealing with your general feelings about yourself. Please circle the answer that is most appropriate for you.

1	On the whole, I am satisfied with myself.	Strongly Agree	Agree	Disagree	Strongly Disagree
2	At times, I think I am no good at all.	Strongly Agree	Agree	Disagree	Strongly Disagree
3	I feel that I have a number of good qualities.	Strongly Agree	Agree	Disagree	Strongly Disagree
4	I am able to do things as well as most other people.	Strongly Agree	Agree	Disagree	Strongly Disagree
5	I feel I do not have much to be proud of.	Strongly Agree	Agree	Disagree	Strongly Disagree
6	I certainly feel useless at times.	Strongly Agree	Agree	Disagree	Strongly Disagree
7	I feel that I am a person of worth, at least on an equal plane with others.	Strongly Agree	Agree	Disagree	Strongly Disagree
8	I wish I could have more respect for myself.	Strongly Agree	Agree	Disagree	Strongly Disagree
9	All in all, I am inclined to feel that I am a failure.	Strongly Agree	Agree	Disagree	Strongly Disagree
10	I take a positive attitude toward myself.	Strongly Agree	Agree	Disagree	Strongly Disagree

Participant Socio-Demographic Details

In this questionnaire I would like to ask you a little bit about yourself. Remember, you will not have to put your name on this sheet and all information you give will be treated completely confidential.

1. Please tell me your age:

- | | | | |
|----------------------------------|----------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> 18 – 22 | <input type="checkbox"/> 23 – 27 | <input type="checkbox"/> 28 – 32 | <input type="checkbox"/> 33 – 37 |
| <input type="checkbox"/> 38 – 42 | <input type="checkbox"/> 43 – 47 | <input type="checkbox"/> 48 – 52 | <input type="checkbox"/> 53 – 57 |
| <input type="checkbox"/> 58 – 62 | <input type="checkbox"/> 63 – 67 | <input type="checkbox"/> 68 – 72 | |

2. Please tell me about any Educational Qualifications you have (*i.e. NVQ, ECDL, GSE, GCSE, O Level, etc.*)

3. Please share your marital status with me:

- ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other _____

4. Please tell me know about your previous or current occupation(s) (*an occupation includes being a housewife/ mother/ caretaker*):

5. Please tell me about the occupation of your Mother and Father:

(If parents are not currently working, please indicate the work they did during their working lives).

6. Please tell me about your Ethnic Background:

White	British	<input type="checkbox"/>
	Irish	<input type="checkbox"/>
	Any other	<input type="checkbox"/>
Mixed	White and Black Caribbean	<input type="checkbox"/>
	White and Black African	<input type="checkbox"/>
	White and Asian	<input type="checkbox"/>
	Any other	<input type="checkbox"/>
Asian or Asian British	Indian	<input type="checkbox"/>
	Pakistani	<input type="checkbox"/>
	Bangladeshi	<input type="checkbox"/>
	Any other	<input type="checkbox"/>
Black or Black British	Caribbean	<input type="checkbox"/>
	African	<input type="checkbox"/>
	Any other	<input type="checkbox"/>
Chinese or other ethnic group	Chinese	<input type="checkbox"/>
	Any other ethnic group	<input type="checkbox"/>
	I do not wish to record my ethnicity	<input type="checkbox"/>

7. How many children do you have? _____

How old are they? _____

8. Are you currently taking any kind of medication (including prescriptions and/or over the counter medicines)

☐ YES ☐ NO

If so, what do you use?

How often to do you use it?

9. Have you ever been or are you currently in any form of therapy or counselling other than our specific therapy group at Women's Aid? (*Therapy/Counselling includes seeing any therapist one-on-one, counselling groups such as Self-help Groups, Self-esteem Groups, etc.*)

☐ YES ☐ NO

If YES, when and for how long have you been in therapy / counselling?

I would like to ask you a little bit about your previous relationships. I know these questions can be uncomfortable and therefore I very much appreciate any answer you can give me.

10. Can you tell me how long ago you left the abusive relationship:

☐ Days ☐ Weeks ☐ Months ☐ Years

11. How long did this relationship last before you left?

<input type="checkbox"/> Less than 5 weeks	<input type="checkbox"/> 1 – 6 Months	<input type="checkbox"/> 6 – 12 Months
<input type="checkbox"/> 1 – 2 Years	<input type="checkbox"/> 3 – 5 Years	<input type="checkbox"/> 6 – 8 Years
<input type="checkbox"/> 8 – 10 Years	<input type="checkbox"/> More than 10 Years _____	

Thank you very much for your time and for completing this questionnaire!
Your help is greatly appreciated!

APPENDIX B QUESTIONNAIRES

The General Self-Efficacy Scale (Jerusalem & Schwarzer, 1993)

Please rate the following statements.

1 = Not at all true **2** = Hardly true **3** = Moderately true **4** = Exactly true

1	I can always manage to solve difficult problems if I try hard enough.	1	2	3	4
2	If someone opposes me, I can find the means and ways to get what I want.	1	2	3	4
3	It is easy for me to stick to my aims and accomplish my goals.	1	2	3	4
4	I am confident that I could deal efficiently with unexpected events.	1	2	3	4
5	Thanks to my resourcefulness, I know how to handle unforeseen situations.	1	2	3	4
6	I can solve most problems if I invest the necessary effort.	1	2	3	4
7	I can remain calm when facing difficulties because I can rely on my coping abilities.	1	2	3	4
8	When I am confronted with a problem, I can usually find several solutions.	1	2	3	4
9	If I am in trouble, I can usually think of a solution.	1	2	3	4
10	I can usually handle whatever comes my way.	1	2	3	4

Information for Research Participants

Dear Participant,

My name is Steffi Winter-Martin and I am a research student at Roehampton University in London. I have had a long interest in helping survivors of domestic violence and in the past have worked with both children and adults who have experienced abuse at home. In my research I am investigating ways to help women work through their experiences.

If you would like to participate in my study it is important that you read the following information carefully, so that you are completely aware what your consent to participate in my study will involve.

If you are unclear about something or if you have additional questions please feel free to contact me or my mentor so that we can answer your questions and resolve your concerns.

The purpose of this study:

Therapy is known to be very effective for many people who feel overwhelmed with a situation in their lives or are unable to get out of a condition without the help of others. For example, group therapy is a valuable method for treating depression, increasing self-esteem or finding support when dealing with an illness.

My research goal is to examine how effective group therapy is specifically for survivors of domestic violence. I would like to understand if and how women feel differently after therapy and whether they are able to gain a new sense of themselves, their situation and possibly their futures because of their therapeutic experiences.

Your benefits:

Your contribution to this research project may make a difference for many domestic violence survivors in the future. Although you are not getting paid to participate your attendance in the treatment sessions might give me and other researchers a better understanding of how therapy affects you and other women like you. Although this treatment is part of a study it has the same benefits as any other form of therapy. If you decide to participate you will have the opportunity to work on your personal problems within this group setting just like you would in treatment at another place.

Your Risks:

All therapy sessions are lead by experienced professionals in the field who are understanding of your situation and will be aware of the difficulties and challenges you have.

Although the group leaders will know how to react in all situations there will be times when the group discusses topics, such as traumatic experiences with batterers, that might make you uncomfortable.

What you can expect:

You will be asked to fill in several questionnaires at various times and attend weekly group therapy sessions for 10 weeks. Therapy sessions will last 1 ½ hours and you will work discuss different topics every week. Even if you happen to move out of the refuge during those 10 weeks you may continue therapy if you wish. There are five surveys/questionnaires you will have to fill out before you attend group therapy and after you have completed therapy. You will also be asked to fill out questionnaires 10 weeks after you have completed the group therapy. These questionnaires will ask you general questions concerning your well-being. For example, you might be asked to rate statements such as “It is easy for me to stick to my aims and accomplish my goals” or “I take a positive attitude towards myself”.

Confidentiality:

I know that your experiences are very personal and difficult to discuss. I assure you that all information you give me in questionnaires or in an interview will be treated confidentially. Strict confidentiality will also be strongly encouraged in all group therapy sessions. I will keep your personal information stored safely and secretly and it will not be given out unless I am worried about your health and safety or that of someone close to you (see below). You will not have to write your name on any of the questionnaires, only on the consent form, which indicates your agreement to participate in this study.

The consent form will be locked away separately from all other information you give. Each survey or questionnaire has a different code number instead of your name, which only I will know. In the publication of any results of this study you will not be identify in any way.

Limits of Confidentiality:

I have to advice you that if during the time of treatment or our work together something comes up that makes me worry about the possibility of you hurting yourself or someone else, I will have to talk to you and the appropriate persons so we can make sure you get help. This is simply for your protection.

Your right to withdraw from the study:

Even if you have signed the consent form and have agreed to participate in my study, you have the right to withdraw from any part of the study at any time – without any objection. You can also change your mind and withdraw from the study after you have participated in several or all therapy sessions without having to give a reason.

Thank you for your participation. Your help is greatly appreciated.

Interview Consent Form

I would very much like to hear about your experience over the past 10 weeks of therapy and I am interested in your opinion. For that reason I would like to invite you to a personal interview with me.

Please let us know if you would like to speak to us further.

We will not contact you regarding the interview unless you give us your permission.

☐ **Yes, I would like to participate in an interview.**

Name: _____

Signature: _____

Date: _____

Please indicate where and when it would be safe for us to contact you in the upcoming weeks:

I can best be reached as follows (Address, Email, or Mobile number):

At this time:

☐ **No thanks, I am not interested in participating in an interview.**

New Contact Information

If you should move out of the refuge (or away) during the course of this project, please complete and send the following form to me so I know how to best reach you. Thank you!!

I have moved!

In the upcoming weeks I can be contacted safely under the following address:

And the following phone number:

At this time of the day/week:

It is / is not safe to leave a message. (Please circle)

Research Consent Form

(Refuges)

Consent Statement:

I (_____) have received and read the information sheet about the study involving the collaboration with this facility. I am informed about the purpose of the study and I am aware that (_____) is free to withdraw the consent to collaborate in this study at any point without any objections.

I understand that residents will be treated with respect and that any information provided by participating residents and staff will be treated in confidence by the researcher. I further understand that the identities of the refuge, as well as its residents and staff will not be disclosed to a third party or in the publication of any findings.

Name: _____

Signature: _____

Date: _____

Please be aware: if you have any concerns or questions about any aspect of this study, please do not hesitate to contact the researcher or her supervisor.

Name: Stefanie Winter-Martin,
Roehampton University, School of Human and Life
Sciences

Contact Address: Roehampton University, Whitelands College
Holybourne Avenue
London, SW15 4JD

Phone No: 02083923000x4561 Email: s.winter@roehampton.ac.uk

Director of Studies: Prof. Claus Voegelé

Phone No: 020 8392 3510 Email: c.vogele@roehampton.ac.uk

Research Participant Consent Form

Consent Statement:

I have received and read the information sheet about the study in which I agree to participate. I am informed about the purpose of the study and I am aware that I am free to withdraw from the study at any point without any objections.

I understand that all information I provide will be treated in confidence by the researcher and that my identity will not be disclosed in the publication of any findings. It is my understanding that my name or other personal information will not be revealed on any art work or in any presentation thereof.

Name: _____

Signature: _____

Date: _____

I give my consent to the display of my personal art work

- ☐ during the project
- ☐ after the project
- ☐ in any publication of the research findings by the researcher

I do **not** consent to the display of my personal art work

- ☐ I direct that my art work be returned to me.

Name: _____

Signature: _____

Date: _____

Please be aware: if you have any concerns or questions about any aspect of your participation, please do not hesitate to contact the researcher or her supervisor.

Name: Stefanie Winter-Martin,
Roehampton University

Phone: 020 8392 3000 x4561 **Email:** s.winter@roehampton.ac.uk

Research Participant Consent Form

Consent Statement:

I have received and read the information sheet about the study in which I agree to participate. I am informed about the purpose of the study and I am aware that I am free to withdraw from the study at any point without any objections.

I understand that all information I provide will be treated in confidence by the researcher and that my identity will not be disclosed in the publication of any findings.

Name: _____

Signature: _____

Date: _____

Please be aware: if you have any concerns or questions about any aspect of your participation, please do not hesitate to contact the researcher or her supervisor.

Name: Stefanie Winter-Martin,
Roehampton University, School of Human and Life Sciences

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Name: _____

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Appendix D

APPENDIX D

THEMES IN ART THERAPY AND PERSON-CENTRED THERAPY GROUPS

Location	Session 1	Session 2	Session 3	Session 4	Session 5
Bexley	Art Therapy and expectations Introductions Current feelings Childhood experiences and parents	Need for space Anger Expressing and owning one's feelings Leaving one's family and children because of domestic violence	Setting boundaries Not being able to say no Revenge/punishment or justice for the abuser	Fears: being found, further violence, further loss (particularly children) Expression of feelings	Anger Expression of anger Frustration in women's lives Finding a sense of themselves

Location	Session 1	Session 2	Session 3	Session 4	Session 5
Ladbroke Grove	Current difficulties Disappointments Regrets Anger Hope put in the intervention Issues of safety Isolation Loss	Family und upbringing Taking control Problems with children Positive and negative Memories Problems in the refuge and with staff Anger	Trauma and understanding what happened to them Fault and self-blame, having tried to make the relationship work Religion and coping (and its impact on staying in the relationship)	Life disappointments Isolation Loss Happy childhood memories (focus on safety and hospitality) "The good old days" Trust Negative aspects of living in a refuge	

Location	Session 1	Session 2	Session 3	Session 4	Session 5
Kingston	Introduction and ground rules Personal Identity Strengths and Weaknesses	Confidentiality Dreams and images Angels and the wish of someone looking after and out for them Money and accommodation Belonging	Living in a refuge Finding a new home Children Loss of family members and saying good bye Closure Concerns about	Court case against husband Being abused Not being able to leave Depression and Suicidal ideation Starting over Birth experience	Support systems Food and traditions from home/cultural differences Experiences of violence and how women feel about them Hope for partner's change

Appendix D

			not being able to create something (self-esteem) Being valued and appreciated		Doing something independently (i.e. travelling)
	Session 6	Session 7	Session 8	Session 9	Session 10
	<p>Frustrations of participants with the therapy group (wish for set themes)</p> <p>Having a home</p> <p>Family and members roles</p> <p>Meaning of family</p> <p>Finding a new partner</p> <p>Being wanted by a man</p>	<p>Women's needs (peace and being looked after)</p> <p>Memories of relationships and their old home</p> <p>Negative childhood experiences</p> <p>Birthday traditions</p> <p>How to nurture oneself</p>	<p>Trying new things and discovering new skills</p> <p>Education</p> <p>Finding safety</p>		

Appendix D

Themes in Person-Centred Therapy groups

Location	Session 1	Session 2	Session 3	Session 4	Session 5
Ladbroke Grove	Experience of violence Children Depression, anxiety and fear Leaving one's family	Telling their personal story Anxiety and fear Shame Current feelings (exhaustion)	Trauma Anger How to manage the future	Boundaries	The past Family
	Session 6	Session 7	Session 8	Session 9	Session 10
	Relationships (with self and others)	Abusive relationship and feelings about it Still being in the past Exploring possibilities for the future			

Location	Session 1	Session 2	Session 3	Session 4	Session 5
Dudley	Introduction What is domestic violence and why women stay	Impact of domestic abuse Issues of power and control	Examining negative thoughts Thinking errors	Tackling self-criticism Impact of self-criticism	
	Session 6	Session 7	Session 8	Session 9	Session 10
	Facing fears Healing the past Bring about change	Becoming assertive Responses to conflict	Looking into the future Goal setting Being kind to yourself	Maintaining good mental health Dealing with stress and anger Problem solving	Relaxation New interests

APPENDIX E INTERVIEW SCHEDULE FOR GROUP PARTICIPANTS

March 2008

1. Welcome, building rapport (sign consent form)
2. Explain why interview is recorded – (Notify participant she can turn off audio recorder any time she feels uncomfortable)
3. Explain confidentiality and limits of confidentiality
4. Explain the purpose of interview
5. Allow for questions

Interview Questions/Guideline:

6. How did you like the venue of the group? (Was there enough room for everyone? Did you have to travel?)
7. How do you feel about therapy (any type) in general? (Do you think it can help people in certain circumstances?)
8. If a friend asked you about the therapy -- how would you describe your therapy experience her?
9. Think of the past weeks of group therapy you have had, was there anything that had an impact on you or has helped you in any way? If so, what?
10. What would you change or do differently in the group? (positive and negative aspects of the group?)
11. Do you feel that you have changed – and if so, how are you now different?
12. What was it about the therapy that has helped you become who you are now?

Appendix E

13. What did you want to get out of the group? (Did you accomplish that goal? Did you get help for specific problems? What has helped with the specific problem?)
14. What are your plans for the future?
15. Allow for questions
16. Remind participant of confidentiality, leave contact details.
17. Good Bye.

APPENDIX F ADDITIONAL STATISTICAL INFORMATION

Table F.1.
Means (SD) of groups on all subscales of the SCL-90-R

	Art Therapy	Person-Centred Therapy	Control	p
Somatisation (SOM)	1.75 (.95)	1.28 (.83)	1.10 (.73)	.08
Obsessive-Compulsive (OC)	2.17 (.92)	1.65 (.92)	1.70 (.82)	.20
Interpersonal Sensitivity (IS)	2.02 (.89)	1.83 (1.08)	1.56 (.96)	.40
Depression (DEP)	2.04 (.83)	1.95 (1.00)	1.87 (.90)	.86
Anxiety (ANX)	1.75 (.86)	1.37 (.89)	1.44 (.89)	.44
Hostility (HOS)	1.63 (1.12)	.79 (.59)	1.07 (.92)	.05
Phobic Anxiety (PHOB)	1.43 (.97)	1.37 (1.14)	1.25 (.99)	.88
Paranoid Ideation (PAR)	2.13 (.79)	1.73 (.95)	1.56 (.92)	.16
Psychoticism (PSY)	1.52 (1.04)	.99 (.94)	1.27 (.81)	.31
Global Severity Index (GSI)	1.86 (.73)	1.48 (.77)	1.47 (.73)	.24

Note: significance is based on $p < .006$ after Bonferoni correction